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ABSTRACT

The conference reported in this document consisted of three symposia and eight workshops each concerned with a different area of violence in America. The document includes an introduction by Annette Zimmern Reed and opening remarks by Dallas mayor Starke Taylor and his wife, Carolyn Taylor. Information from the three symposia is given in the areas of violence as a special health problem for minorities, issues related to victims of violence, and the costs of violence, and its impact on future legislation. The eight issues examined by the workshops were child sexual abuse, child abuse, elder abuse, spouse abuse, assault and homicide, rape and sexual assault, suicide, and injuries due to risk-taking behavior. Also included is information from a panel discussion on regional data collection and analysis. Addresses and academic papers from the proceedings include: (1) "Violence as a Health Problem in the Southwest" (Shervert Frazier); (2) "Life Cycle of Violence" (Larry Herbert); (3) "Selected Issues of Violence" (Herbert Nickens); (4) "Violence as a National Health Problem" (Faye Abdellah); (5) "Victims of Violence" (Kern Wildenthal and Lois Haight Herrington); (6) "Homicide and Assaultive Violence" (Keith Harries); (7) "Learning from Patterns of Violence" (Joseph Warshaw and Mark Rosenberg); (8) "Criminal Homicide and Assault: A Criminological Perspective" (Paul Blackman); (9) "Violence as a Health Problem: The Example of Child Abuse and Family Violence: The Alcohol Connection" (Jerry Flanzer); (10) "The Emergency Medical Response to Violent Crime Victims" (Roy Allen); (11) "Spouse Abuse" (Anne Helton, Elizabeth Anderson, and Judith McFarlane); (12) "Medical Costs of Violence to Taxpayers in Harris County, Texas: Pilot Study" (Louis DeNino); and (13) "A Violence Monitoring and Surveillance System for the Southwest Region: A Research and Demonstration Project" (Linda Lloyd). An address by steering committee chairman Robert McGovern, the program schedule, biographies of participants, and a list of convention-planning pointers are appended. (NB)

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VIOLENCE IN AMERICA

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PROCEEDINGS OF THE SOUTHWEST REGIONAL RESEARCH CONFERENCE, NOVEMBER 6-8, 1986

ANNETTE ZIMMERN REED, PH.D.
PROCEEDINGS EDITOR

JANE C. SULLIVAN
CONSULTING EDITOR

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PUBLISHED BY THE FAMILY ADVOCACY PROGRAM
UNITED STATES AIR FORCE

LYNDON B. JOHNSON SCHOOL OF PUBLIC AFFAIRS
THE UNIVERSITY OF TEXAS AT AUSTIN

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Southwest Regional Research Conference

VIOLENCE IN AMERICA

November 6-8

THE PLAZA OF THE AMERICAS HOTEL

DALLAS, TEXAS

Sponsored by
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- ◊ Violence as a Special Health Problem for Minorities

Introduction

The idea for the Southwestern Regional Conference started in October 1985, when a two-day workshop on the topic of violence was convened in Leesburg, Virginia, chaired by Surgeon General C. Everett Koop. Entitled "The Workshop on Violence and Public Health," it was attended by prominent leaders representing various professional disciplines as well as most regions of our country. After the meeting, the Surgeon General made the following statement: "Violence is a public health problem because of the toll it exacts in injuries and deaths, especially among younger people. The solution to the problem of violence requires a total community effort. The health-care system must help to make victims whole emotionally as well as physically and help prevent further violence. Providers must be alert to the special needs of those most at risk of becoming repeat victims."

Several recommendations emerged from the Surgeon General's Leesburg violence workshop. One of these recommendations was to promote regional spinoff efforts in various parts of the United States to continue to explore and discuss solutions to this pressing issue. During the conference, leaders and representatives from Dallas, Houston, San Antonio, Louisiana, Oklahoma, the military, and the American Indian population initiated plans for such a spinoff conference. The result was the November 6-8, 1986, Southwest Regional Research Conference on Violence in America, which took place in Dallas, Texas. The conference was attended by 418 people.

This conference consisted of three symposia and panel-directed workshops that encompassed eight different areas of violence, interpersonal and self-inflicted. Each panel consisted of at least three members: a national authority, a regional investigator, and a moderator from the conference steering committee. The first day was concerned with the status quo, and the second day dealt with the future.

The conference participants formulated as a long-term goal the establishment of a regional data collecting system that would encompass all areas of violence affecting infants, children, adolescents, adults, and the elderly. The School of Public Health in Houston is proceeding with its injury research center plans and the Texas Department of Health is presently exploring the possibilities of a regional data collection system with the region's other four state health departments.

In publishing this material, we were obliged to take a certain amount of editorial license in summarizing or excerpting even the most outstanding presentations in order to bring down the length from 665 pages to our limit of 200 pages. Further difficulties were encountered due to faulty tape recordings, scheduling mixups, transcribers who were unfamiliar with the subject matter, and so on. We have worked hard to ensure accuracy and equitable coverage, but we know that some of the participants will look in vain for that very salient point or that little introductory salvo that popped into your mind just as the plane was landing. Please accept our apologies for any omissions and try to view the

proceedings not as a recording of everything that happened, but as a representation of a very important convocation, which we hope will be a turning point for our approach to violence.

These proceedings have been published and disseminated through the generous assistance of the U.S. Defense Department's Air Force Family Advocacy Program.

Annette Zimmern Reed, Ph.D.
Conference Director and Proceedings Editor

Plenary Session

Welcome and Opening Remarks

Chairman — Kenneth Z. Altshuler, M.D., Professor and Chairman, Psychiatry Department, University of Texas Health Science Center at Dallas

Recorder — Charles Hemphill, M.A., Counselor, Dallas Challenge, Inc.

[Dr. Altshuler introduced Dr. Annette Zimmern, Senior Scientist with the U.S. Public Health Service and Director of the conference, who explained that Surgeon General C. Everett Koop had been hospitalized and that therefore the luncheon address he had been scheduled to give would be delivered instead by Deputy Surgeon General Faye G. Abdellah.]

Mayor Starke Taylor: I'm very pleased to be with you this morning. I'm especially pleased that all of you were willing to take time to come to this regional conference to address a problem that directly or indirectly touches all of us and one that has become more obvious in the last few years. As the Surgeon General has said, "Violence can no longer be viewed as a problem of desperate acts by individual offenders." It is so widespread that it is a public health problem as well. Many of the victims are young people and many are victimized over and over again. The search for solutions must be a community effort.

Let me elaborate a little on the community effort aspect and how important we in Dallas think it is. The crime situation in Dallas is something we're not proud of. As a result, I formed a task force a year-and-a-half ago and they have come up with a program that I think will be a model certainly for the state of Texas and maybe even for the entire United States. These people represent every organized element in crime prevention. We have attorneys, district attorneys, sheriffs, the police, the Pardons Board, people involved in drug-abuse prevention and treatment, people dealing with juvenile delinquents and juvenile drug offenders, etc. There is not one area of crime that is not represented on that commission. They will take their plan to Austin. Our legislature convenes in January and we already have over 250 cities in the state of Texas that are signed up on that plan.

Unfortunately, it's going to take money and, as you probably know, Texas is having some problems that are making it difficult for our legislature. But I am convinced that the people of Texas and probably the entire United States do not mind paying whatever they have to pay in increased taxes to try to solve these crime problems. I've never heard one person say to me that it's too expensive. It's going to take a grass roots effort. You cannot do it just with the people of Dallas. We've had the chief of police from Houston here and he has signed up. The mayor of Ft. Worth has been here and he has signed up. We have the leaders in the state involved. Many of the smaller cities are involved, and we're working on the others. In January we will go to Austin and we expect to have 1,000 people down there to rally. And I'll guarantee you the politicians in Austin will sit up and

take notice. That's what gets their attention--when you have that many people all united, all wanting to do something.

I commend you again for taking your time and being involved in this because what you are doing also is related to crime and health. I challenge you to make the most of these three days. They are important days. You are working on a concern that is critical, not just to this region, but to the entire nation. I personally will be looking forward to seeing the recommendations you come up with. Hopefully, there will be something that we can do at City Hall to cooperate with your efforts. Thank you very much.

Mrs. Carolyn Taylor: Good morning. I am here today as a woman, a volunteer, but most especially, as a mother who has lost a son to just the type of violence that you're here to talk about today. It is a special honor to have the opportunity to say thank you to you all: volunteers who have given so much of your time and your money to help solve problems caused by violence. This is an issue which affects each of us, either directly or indirectly. It's on the front page of the newspaper almost every day. It's headline news on the radio and TV. It's a major theme to help sell movies. We have even come to the point of watching live TV coverage of actual shootings in progress. In fact, violence has become so common that most people now just seem to take it for granted.

In the meantime, we as a society are being asked to pay more tax money for prison cells, court rooms, halfway houses, counseling programs, health care, and educational programs. As violent behavior continues to escalate, the number of victims continues to escalate along with it. Unfortunately, there is a far disproportionate number of women, teenagers, and female children who are victims of violence. All too often the people who are already unable to help themselves are beaten down by violent behavior. And even though the professionals are doing as much as they can hampered by lack of money and personnel, there is still so much work that needs to be done.

On behalf of all the people whose lives have been touched by violence, I want to say thank you and God bless each of you who have unselfishly given of your money and your time to help those who need you. In addition to helping us provide housing, clothing, counseling, and education, the precious volunteer provides the love and the caring and the help we really need. The volunteers in this room really represent faith in action. I want to extend a special thanks to the many volunteers who worked so hard to help us make this very important conference a reality and a success. Thank you all for being here today.

I know all our prayers and best wishes are with the Surgeon General. It is indeed critical that we as a society quit turning our backs on the frightening and growing problem of violence. Thanks to Surgeon General Koop's efforts and those of everyone here, we have taken that issue off the back burner and are now looking at it as a serious public health issue. I believe that the people of this city, this state, and this country will come forth to help us solve the problems facing us once the problems are outlined and the solutions drawn. Surgeon General Koop has helped us outline the problems and I know the people attending this conference will help us obtain the solutions to these problems.

[Mrs. Taylor presented the key to the city of Dallas to Surgeon General Koop's assistant, Ted Cron, who accepted on behalf of the Surgeon General.]

Keynote Address

Violence as a Health Problem in the Southwest

Address Shervert Frazier M.D., Director, National Institute of Mental Health

Dr. Shervert H. Frazier: It gives me a lot of pleasure to be back in this part of the world and to have the opportunity to see so many good friends. It's particularly pleasing to be part of this conference which, I believe, is of extra special significance. This is the first regional meeting to build on the Surgeon General's workshop on violence and public health, which was held in Leesburg, Virginia, in 1985. I want to congratulate the organizers of this conference for assembling so many informed and caring people to meet the challenges which are outlined in this truly excellent program. What you do here is being watched all over this country, and I know it will serve as a model for other regions which are planning similar meetings. For example, Seattle will be the site for such a gathering next June, and plans are underway for a similar conference in Indianapolis. This meeting and those which come in the future are outgrowths of an increasing understanding in this nation that violence is a health as well as a criminal justice problem. This is not news for a lot of workers in the health sector--professionals who have been actively involved for years with child abuse, child sexual abuse, rape, suicide, and other forms of violence. But there is a growing awareness that other forms of violence, spouse abuse, elder abuse, assault, and homicide, are also health problems which require health interventions. As a clinician and a psychiatrist, I have personally been witness to the long-term pain, both physical and psychological, that violence has caused so many people. When violence affects a family member, the entire family is also affected. Conferences such as this recognize the pervasiveness of violence and its resulting trauma. As awareness goes beyond the individual clinician to a national level, needed health interventions and prevention programs will be implemented.

National recognition of violence as a health issue hasn't happened overnight. The many years of research on violence by the National Institute of Mental Health (NIMH) and other organizations have opened the doors behind which violence, secret and underreported, has been taking a toll of victims in our society for years. The costs of violence in this country--the physical costs, the emotional costs, the social costs, the economic costs--are incalculable. For example, the first survey on a national level of family violence, sponsored by NIMH in 1975, found that the home, which we often think of as the site of nurturance and love, was also, more than anyone ever imagined, a battleground. We learned that each year almost 2 million American women are severely beaten by their husbands and 36 of every 100,000 children are severely abused by a parent. A 1985 follow-up survey brought us the good news that violence toward children had declined by 47 percent since 1975. The bad news is that these figures do not adequately reflect child sexual abuse. Hard data on the prevalence of child sexual abuse remains inaccessible, but

case studies are indicating far more than was ever suspected. NIMH research indicated that child molesters, pedophiles who tend to victimize those most vulnerable (i.e., children dependent on them for love and security, their children, stepchildren, relatives, or the children of their lovers) are not adverse to molesting children outside of the home. Further studies find that sex abusers typically begin their asocial behaviors by age 15. And they commit many more varied sexual crimes than were previously realized by mental health experts or were ever reported to the police.

The implications of child abuse, sexual abuse, and neglect for the future of the health-care system and our society as a whole are worrisome. A ten-year study done at Harvard found maltreated children to be at high risk for future psychopathology. These children are similar to adults with post-traumatic stress syndrome in the ways in which they deal with their feelings and their impulses. They tend toward attention-deficit disorder, childhood depression, conduct disorders, and delinquency. Right here at the University of Texas, Dr. Lawrence Claman is following a group of physically abused preschool children to learn which interventions may keep these youngsters from requiring residential care. The costs of residential treatment, as you know, have risen exponentially in the past five years. Possibly even more worrisome than the direct health-care costs incurred by these children today is the prospect of future health-care costs associated with troubled adolescents who themselves often become abusive parents.

Unsettling findings have also emerged from the first concerted research program (established within the NIMH) on rape and sexual assault. It was found that women are more often raped by men they know than by strangers. Acquaintance or date rape, as this form of violence is called, is more guilt-producing in victims than stranger rape and is therefore less often reported.

NIMH studies have also revealed that battered women are rarely identified by emergency room personnel as victims of battering. Four times more cases of assault appear in hospital records than are reported to the police. Nonwhite women die more often from their injuries than do white women, but poor women, white or black, are most often the victims of battering. The costs of battering go beyond injury and pain. These women have disproportionately higher rates of subsequent hospital visits for psychiatric disorders, for alcohol and drug abuse, and for suicide attempts. Pregnant women were found particularly vulnerable to battering in a July 1985 study by researchers Elizabeth Anderson and Judith McFarlane of Texas Woman's University. Of 290 white, black, and Hispanic women between the ages of 18 and 43 living in the Houston area, 39 percent were seriously battered. None were assessed for abuse by their health-care provider and none knew where to go for help. A fascinating NIMH study on the etiology of spouse abuse found that high numbers of couples were engaged in some form of aggression before they married. Of 400 couples interviewed, 24 percent of the men and 40 percent of the women reported carrying out minor aggressive acts such as shoving or pushing each other. Severe aggression was committed by 7 percent of the men compared to 17 percent of the women. However, as is typically the case, women suffered more serious injuries. Most of the couples married despite their histories of mutual aggression.

The story of violence against the elderly is different in terms of quantity but not quality. Most families are involved in heroic efforts to care for the older family members. Unquestionably, there are incidents of abuse and neglect, but there is no really good, hard evidence of their prevalence. The sense of those who work with the elderly is that it is a relatively rare occurrence. Rape among older women, unlike in younger populations, is not primarily acquaintance rape, but rather occurs usually secondary to burglary or robbery. The older rape victim just happened to be home during the break-in, and thus, is doubly victimized.

Although crime victimization of the elderly is on the low side compared to other age groups, fear of crime is highest among older people. Afraid to leave their homes, they suffer social isolation and all its physical as well as mental consequences. The sad irony is that older people are just as likely to be criminally victimized in their homes as on the streets.

While NIMH research has shed light on the relationship of interpersonal violence and health, the 1979 Surgeon General's report *Healthy People* brought a new understanding of the impact of lifestyles and environment on health. We learned that the major killers of people under 45 years of age were automobile accidents, suicide, homicide, and diseases attributable to smoking, alcoholism, and poor health habits. Alcohol, drugs, and firearms are clearly implicated in the deaths of our young people. Alcohol use is suspect in numerous automobile fatalities and associated with all kinds of violence. The National Institute on Alcoholism and Alcohol Abuse estimates that alcohol is involved in up to 60 percent of murders, between 20 and 40 percent of suicides, over 70 percent of assaults, 50 percent of rapes, and 40 percent of child abuse fatalities. The only good news comes from the NIMH family violence data which indicate that alcohol is less often involved in spousal violence than previously thought. Only 25 percent of spousal violence involved alcohol, but the heavier the drinking, the more severe the violence. Our sister institute, the National Institute of Drug Abuse (NIDA), finds that drug use and abuse go hand in hand with violence. A preliminary NIDA study of over 300 youngsters between 12 and 17 years of age in Miami finds that 35 percent have been victims of violence related to drugs, and 33 percent admit to committing drug-related violence during the past year. LSD, PCP (angel dust), and the amphetamines are known to cause neurologically induced paranoia and sometimes subsequent violent behavior. Drug or alcohol use precedes 17 percent of all delinquent acts.

Suicide, the third leading cause of death in the 15-to-24-year-old group, is of particular concern to me. Over the past 1-1/2 years I've been immersed in suicide studies as the head of the HHS secretary's task force on youth suicide. As you know, this is a rapidly growing problem, characterized by clusters of teenage suicide in some of our city and surburban areas. On the secretary's behalf, I have convened three major conferences on youth suicide, involving experts from all the disciplines, to determine the causes of youth suicide and to develop strategies to intervene and to prevent this tragic loss. The first conference was on risk factors for the identification of children and adolescents who have high risk of suicide. The second conference was on prevention and intervention. We had a large number of people from all walks of life--especially from the counseling field,

hotlines, crisis-intervention and educational groups--who came together to tell the health community what they were doing in these particular communities and areas. The third conference dealt with strategies for the future, looking at how federal and other agencies need to combine their efforts and do research to get at the new knowledge necessary for intervention and prevention.

Most suicides and homicides have been and are increasingly committed with guns. This should be of particular interest to citizens of this region where homicide rates are the highest in the nation and the availability of firearms is considerable. We have to face the issues involved. These issues are especially relevant to the 1985 report of the HHS Task Force on black and minority health. This report brought out, perhaps more starkly than ever before, the role of homicide as a major killer of black men and women, and of Hispanic and Native American Indian men.

All of these factors contributed to bringing about a most extraordinary congregation to which I alluded earlier in my talk--the 1985 Surgeon General's conference entitled "The Workshop on Violence and Public Health." At that conference, I was privileged to join some 200 people who came from all parts of this country to grapple with the complex issues involved. It was acknowledged at that conference that the pervasiveness of violence and the toll it exacts on health and mental health in this country require a commitment of the total community and the total health-care system if solutions are to be found. It's a real tribute to the initiative of the southwestern people that yours is the only PHS region which began the active planning for this conference as a follow-up to the meeting at Leesburg. It is also highly desirable both because of the specific problems and the special resources to be found in this region.

As I mentioned before, the South and parts of the Southwest have a long history of the highest homicide rates in the nation. Members of minority groups in the five southwestern states appear to be especially at risk. Homicide rates among Hispanics are more than double those for non-Hispanic whites, 21.6 per 100,000. The homicide rate among Native Americans is not dissimilar--19 per 100,000--somewhat higher than the 18.1 per 100,000 nationally. Projecting from national figures, it is likely that Native Americans in the Southwest are also dying in above-average rates from accidental death and suicides and blacks from homicides and accidental death. Nationally, 60 percent of homicides are committed with guns.

While the problems loom large, it's very significant and evident that the citizens of the Southwest are willing to respond to these problems once they are identified. For example, the organization of "Impact 88," a Dallas program to address serious problems facing adolescents, has made tremendous strides through the leadership of Mrs. Taylor and others. This effort was stimulated by receipt of a grant from the Robert Wood Johnson Foundation--a grant only given to communities that can demonstrate above national averages in five serious teenage problems. Dallas County, its citizens sadly found out, was eligible. It had 5 times the average drug-abuse violations, 3 times the number of homicides, 2.5 times as much venereal disease, 1.5 times the number of teenage pregnancies, and 1.5 times the national average of suicides. All the Dallas community groups pulled together and specific goals were developed to help their young people. Impact 88 continues to grow. In

fact, it's been so successful that another Robert Wood Johnson Foundation grant may be forthcoming.

I have every confidence that this conference will demonstrate that the resources, the talents, and the caring which have been exemplified in Impact 88 can be applied to an even more challenging and broader arena--this whole southwestern region. This conference will be making new health initiatives in the Southwest and will, I believe, have a major impact on reducing violence in our society. This is a fine program--an excellent blend of topics and speakers--and an audience that is already part of the solution. When people are this interested, and this well-organized, and they get together, the solution is in the process and I look forward to the productive outcome of this conference and your agenda. Thank you.

Plenary Address

Life Cycle of Violence

Address Larry Hebert, M.D., Professor of Pediatrics, LSUMC, Baton Rouge

Dr. Larry Hebert: Good morning. The title of my topic today is not my own. Annette Zimmern coined it, formulated it for me, and gave me time to put these facts together. After listening to Dr. Frazier's overwhelming statistics on the problems, I hope I can give you a little insight into why people become violent during adolescence and during adulthood.

Violence is the name that we give to the more extreme forms of aggression that we consider destructive. After Dr. Frazier's talk, I don't think there is any question in anybody's mind that there is much violence in our society. Unfortunately, studies on violence reveal that Americans are more likely to encounter personal injury or violent death from the aggressive behaviors of other family members than from strangers on the street. The violent or aggressive behavior can be between spouses in the form of spouse abuse, parent to child in the form of child abuse or child sexual abuse, or from child to parent. The most common aggressive or violent acts between family members that I have personally come across are slapping, kicking, biting, punching, hitting with an object, beating up, threatening to use a gun or knife. The most serious is the actual use of a knife or a gun in hurting another family member. Although the family traditionally has been viewed as an institution that serves to diminish violence in our society, the truth is that the family serves as a breeding ground for the life cycle of violence in about 50 percent of our American homes. It is in the home that adults try to resolve problems or change behavior, and home is where children learn to accept violence as an inevitable reality.

In my opinion, the life cycle of violence most often begins in childhood, and its consequences are experienced throughout an individual's life. Because of the high frequency and the seriousness of family violence, close attention must be paid to the patterns of violence and the channels of discharge of violence within the family unit through the life cycle. My own thoughts on this subject of violence have been stimulated and developed largely during the last fifteen years as a consequence of working with abused children and their parents. Child abuse is a form of violent behavior that involves not just the expression of aggression against a member of our own species, but by adults against their own children. This is the most destructive and long-lasting form of violence anyone can ever experience. I would like to describe a few of my ideas about how many forms of violence originate in childhood as a result of sociological, biological and psychological variables, all of which are determined and controlled by a child's parents.

Before we get into the abnormal aggressive patterns of violence, I would like to review briefly the stages of development of a child within a loving, nonviolent family. We will then be able to better understand the detrimental effects that violence and abuse have on a growing child. Consider that Baby Jane is born into your family today. Whether a

grandchild, a child, or maybe just a close relative, Baby Jane did not have a choice regarding what type of family she would be reared in or what type of parenting style she would be subjected to during these formative years, but her destiny has already been significantly determined by her birth. We will assume that your family is a loving one, and a nonviolent one, and that Baby Jane, when she arrives, will be its most precious possession. She will receive a genuine welcome with deeply felt joy. I know that Baby Jane's parents will love and accept her and they will instinctively give her consistent, warm care--the most essential ingredient of an adequate and effective parenting style. I define *consistent, warm care* as not only the parents' always being there to care for the baby's physical needs but also consistency in the way they hold her or him and the way they smile and talk to her or him. It's not only what they do, but how consistent and how repeated these interactions are that have the greatest impact. The newborn, Baby Jane, will begin life almost as a psychological blank. She will have certain innate and biological characteristics. We know that prepartum influences will have some effect but probably will be very small in importance. Hereditary tendencies definitely will have some effect. But I believe that consistent, warm care can overpower most of the innate characteristics with which that baby is born.

Baby Jane's only source of knowledge and feelings about the world will come through her five senses. Her personality structure will be shaped by the richness of, and the consistency of, input from seeing, hearing, smelling, and testing a variety of things around her, as well as the tactile stimulation of rocking, holding, and cuddling. When I analyze what kind of a home a child is being reared in, one of the main questions I ask a parent is, "Do you have a rocker?" If they tell me that they have a rocker and they rock their children, I think they have said much. Research has shown that sensory stimulation in the first five to ten days of life will have a great effect throughout this person's life. From birth to eighteen months, Jane will learn to trust. She will develop secure feelings because of the consistency of her parents. They will always be there caring for her physical needs but also there to hold her, smile and talk to her. It is between eighteen months and thirty-six months that a child will develop physical independence, self-control, reality perception, and positive self-image. These can only be attained if Jane's parents provide her with acceptance and security. The parents' own high self-esteem and their willingness to provide consistent, warm care will enable Jane to go through this phase with relative ease.

During these developmental stages and over the next few years, probably by age five, Jane learns from her parents to distinguish right from wrong. She will also begin to internalize rules provided by her parents. She will accomplish this through two means of indoctrination: first, the promise of love and approval from her parents when she accepts and follows the standards, and second, the threat and use of punishment. It is through the combination of Jane's innate characteristics, her personality structure, shaped by her parents, and her parents' instruction and modeling of appropriate nonviolent behavior during these early years, that will greatly determine her values and behavior. The basic drives, actions, and desires that Jane will possess later in life will be determined to a large extent by her parents during these formative years. The successes and failures which Jane will experience during these years will be internalized and will determine the manner in

which she will express anger and frustration. We must recognize that the most potent controls and directions of aggression and violence for Jane, and for most children, will be learned from their parents. The bottom line is that Jane will have the best possible chance to enjoy a healthy, happy, nonviolent childhood, adolescence, and adulthood if her self-esteeming parents shape her personality structure by using consistent, warm care and nonviolent child-rearing practices.

Now that we've looked at the normal events in a nonviolent family, let's look at a case history of a child with whom I have personally been involved. Her name is Ann. I will call her mother Mrs. X. Mrs. X was born illegitimately, worked as a barmaid, had many heterosexual affairs, and abused alcohol at a very early age. She continued to use alcohol throughout her daughter's childhood. Mrs. X was abused by her husband and retaliated with a gun. Her pregnancy was illegitimate and unwanted from the time of conception up to delivery. After delivery, however, she demanded that Baby Ann should be kept right next to her.

When Baby Ann was brought home from the hospital, she was beaten many times by her drunken mother and her mother's boyfriend, as well as sexually molested by one of her mother's boyfriends. Another destructive factor was that the mother left Ann with multiple caretakers, sometimes not returning for two to four days during her drunken episodes. Upon her return, the mother would be guilt-ridden, overpossessive, and overprotective of Ann. This pattern of abandonment and overprotective behavior was repeated over many years. During the mother's alcoholic binges, Ann was subjected to an inadequate and inconsistent supply of food, clothing, and shelter. The mother's parenting style and child-rearing practices influenced Ann to incorporate as parts of her personality structure four main determinants: rejection, deprivation, physical pain, and unpredictable environment. As a result of this parenting style, Ann didn't progress through the separation and individuation stage which occurs around eighteen to thirty-six months. Therefore, she arrested at that point and developed personality defects at that particular age. The main reason that she arrested was that her mother was unable to provide the emotional support and the material supplies that the child needed to progress through this stage. Because of the delays and arrest that Ann suffered at this age, she developed maladaptive behavior problems. During her preschool years, she developed severe temper tantrums, expressions of rage, and manipulative behavior. During her elementary school years, she had angry outbursts. She assaulted the teachers and destroyed property at school and at home. She engaged in seductive behavior and had poor peer relationships and a short attention span. When adolescence came around, she manifested uncontrolled aggression and absolute refusal to trust authority. She ran away from home repeatedly, used drugs, and had sex. Finally she committed armed robbery. We admitted her at age fifteen for long-term treatment. She was diagnosed as an antisocial personality.

When an abused child like Ann becomes an adolescent, all the effects of years of abuse and rejection come out clearly. The uncontrollable acting-out behaviors were manifestations of long pent-up rage against herself and her abusing parents. In my opinion, it's not only the actual amount of physical punishment that affects the child, but also the inevitable accompaniment of diminished love and approval, as well as increased criticism.

This emotional abuse and lack of empathetic understanding are probably more important in later adjustment than the simple fact of physical punishment or abuse.

Over the past several years I have interviewed and participated in the treatment of emotionally disturbed adolescents at the Adolescent Psychiatric Hospital in Baton Rouge. More than 90 percent of the adolescents treated at the detention center and in the hospital had been physically or sexually abused or neglected at a very early age. From interviews with these abused children, there have emerged three distinct traits common among their parents: they make inappropriate demands on their children, beginning in infancy; they make inconsistent and unpredictable use of physical punishment, beginning in early life; and they lack empathetic parenting. Other factors play key roles: chaotic family structure, spouse abuse, drug abuse, divorce, and mental illness. Another frequent factor is that the family itself often moves from one place to another, either running away or having been evicted from their apartment or mobile home.

Violent acts committed by abused adolescents most often include robbery, assault, and murder. These physically aggressive acts can be against members of the family or society in general. I would like to quote from an article in our *State Times* in Baton Rouge, April 1983, entitled "Growing Fraternity of Rage: Kids Who Murder Their Parents." Three cases from this article particularly caught my attention. From Lake Village, Arkansas, a fourteen-year-old strangled his mother with his hands, then with a cord. He said it was because she had beaten and mistreated him from the day he was born. In Lafayette, Louisiana, a twenty-five-year-old man killed his mother by shooting her in the face with a gun. Why did he do it? Because she had beaten him repeatedly since he was a very young child. In Cheyenne, Wyoming, a sixteen-year-old hid in the garage until his father came home and killed him with a shotgun. The father had beaten his wife and son and sexually abused his daughter for many years. The son's only comment was "we are now all relieved." The FBI reports that 250 parents are killed by adolescents each year.

From these dramatic examples, it is obvious that abused children who become adolescents or adults can and do release pent-up rage, pain, and anger onto their parents or onto themselves by committing suicide. Unhappy, abused teenagers more often vent their anger and their pain in less violent ways, such as running away from home, stealing, skipping school, and just sleeping around. Teenagers who are abused and exposed to violence in the home lack the emotional and developmental skills to deal with their problems other than by acting out against society and their own family members. Some unhappy kids who wish their parents were dead because they didn't care for them or abused them just end up killing themselves instead; these constitute a high percentage of adolescent suicides. When the abused adolescent does reach adulthood, he has an extremely good chance of becoming a violent adult--a wife-abuser, a child-abuser, a murderer, a rapist, or a habitual criminal. According to Dr. Steel, a psychiatrist from Denver, the most common element in the lives of violent or abusive adults is the experience of being neglected or abused to some degree by caretakers during their formative years. At this point in time, we do not know exactly how often the culturally prevalent pattern of child abuse can explain the acts of violence that occur within the family or on the street; however, studies on violent adolescents and adults who were abused by their parents

during childhood come very close to demonstrating one-to-one cause and effect. And although it must be acknowledged that there are adolescents and adults who enjoy a fairly healthy and successful life style in spite of violent or abusive experience during childhood, I have to say that I have seen very few of them in my fifteen years of observation.

Let's summarize. A parenting style of consistent, warm care can prevent rejection from the first breath of life. It does go a long way toward realizing the immeasurable potentials of happiness and harmony in generations to come. Rejection, deprivation, physical pain, and an unpredictable environment are the primary determinants in the maladjustment of an abused child from infancy through adulthood. Child abuse guarantees tragic and expensive results: more runaways, more suicides, more drug abuse, more juvenile delinquents, more habitual criminals, and yet another generation of abused and neglected children. The adolescent or adult who was abused or rejected by caretakers during early childhood will almost certainly be a violent and/or emotionally disturbed person who can and does release pent-up rage against self, family, and the world. Substance abuse, divorce, and a chaotic family structure are distinct sociological variables which often potentiate the severity and types of violence committed by or on family members. Every day in homes throughout our country, violent acts of child abuse, child sexual abuse, and spouse abuse occur about 17,000 times. Therefore, the beginning of the life cycle of violence occurs in an unbelievable number of our American homes. Thank you very much.

Plenary Address

Selected Issues of Violence

Address Herbert Nickens, M.D., Director, Office of Minority Health, Washington, D.C.

Dr. Herbert Nickens: I'm pleased to be here today. I have to say this is one of the best organized conferences I've been to in a long time. I'm going to talk about three topics related to minorities and violence. First, I want to talk about the American context of violence because I think that we always have to keep in mind that minorities are Americans. Second, I want to touch on some of the theories that have been postulated over the years relating to minorities and violence. And finally, I want to talk a little bit about opportunities for prevention and for intervention. The Office of Minority Health (OMH) was created by Margaret Heckler, who at that time was secretary of HHS. Reviewing the U.S. annual statistical compendium for 1983, Heckler was struck by the disparity between minority and white health status in this country. As a result, she created a task force in government to work on that problem and assembled directors and deputy directors of major units within the Public Health Service and other parts of the department. One of the important things that came out of that task force was the superb executive summary that it produced. This was first presented at a press conference just a year ago; it now runs to a 8 volumes and a little over 3,000 pages. The core findings of the task force was that of the 40 or 50 causes of death in the country that were investigated, 6 of these accounted for 60 percent of the "excess deaths" among minorities. The term *excess deaths* is defined as deaths that would not have occurred if minorities had the same death rates as the white population. Among those 80 percent of excess deaths, the six causes were cancer, cardiovascular diseases and stroke, chemical dependency (in this case, only deaths due to cirrhosis of the liver in alcoholism were used), diabetes, violence, and infant mortality. Violence, in the context of this report, refers essentially to homicide. Accidents and suicides were touched upon, but homicide was the major focus.

The first issue is the whole American context of violence. In the late 1960s H. Rap Brown, a civil-rights firebrand, said "Violence is as American as cherry pie." We know that America has the highest rate of homicide in the industrialized world. The white homicide rate alone is higher that that of any other industrialized nation by a factor of 2. The violence commission started in 1969, chaired by Milton Eisenhower, opened its report with an illustrative example of the American response to violence. I quote from the report: "On September 26, 1872, three mounted bandits rode to the gate of the Kansas City Fair where a crowd of 10,000 had gathered. They shot at the ticket seller, hit a small girl in the leg by mistake, and made off for the woods with less than $1,000." In reporting the incident, the *Kansas City Times* raved, "so diabolically daring and so utterly in contempt of fear that we are bound to admire it and revere its perpetrators." The Kansas City newspaper

commented two days later, "Nowhere else in the United States or in the civilized world possibly could this thing have been done."

There are a number of factors which are frequently offered to explain American violence in our history. This country was created by an interminable stream of propertyless individuals with powerful ambitions and acquistive instincts. They marched across and dominated a huge continent 3,000 miles wide in a very short period of time by historical standards--about 250 years. Subsequent waves of heterogeneous immigrants competed for the good life with people already living here. Americans have a passion for freedom, individual action, and egalitarianism. We fought a revolutionary war to get freedom. But the values of equality and freedom had to be a little flexible to allow us to compete with Mexico and take territory, to fight with Indians and take their territory, to survive a slave trade, to traffic in slaves, and simultaneously to support the swift execution of horse thieves. Our heroes and our norms are all born of this era, and it's a mixed bag of heroes such as Daniel Boone and villains whom we tend to lionize, such as Jesse James. Present-day cinematic heros such as "Rambo" and the "Terminator" are complete with special effects and can be relied upon to attract millions of adoring fans at the box office.

This widespread acceptance and celebration of violence makes it difficult for Americans to acknowledge a key reality: violence committed for a good cause is violence nonetheless. Some of the positive traits in our country also have sinister sides, and we pay a dear price for them. I think especially as we become more and more a mature nation (with no geographic frontiers left to conquer), we have to think about the price that we're paying for these traits and ask whether or not we can keep some of the good and get rid of some of the bad.

The second point I want to talk about is some of the theories that have been advanced regarding excess minority homicides. This tremendous excess, this relative risk for homicide which is known historically in the black population, is on the order of 6 times that for the white population while the lifetime risk for a black male dying of homicide is about 5 percent. We have also learned that there are excesses in homicide among native Americans and Hispanics. Most of the references that I'm going to make are to the black population because those numbers have been known for a longer time.

There has been a lot of focus on black violence. Many of the theories have focused on various kinds of subcultural theories, i.e., that some racial or regional subcultures within our culture allow or encourage violence. One theory postulates an inherent black inability to control violent impulses, a sense that the norm of violence is especially acceptable among blacks. Sometimes there is a sympathetic twist, as in the racial theory, sometimes referred to as "black rage" theory, that violence is a rational response to racism and deprivation. Finally, there have been theories related to socioeconomic status. Studies of the poor, the real subculture of violence, suggest that if you adjust racial disparities in violence (or at least in homicide) for socioeconomic status, they do diminish tremendously.

Theories are useful, but they often serve polemical purposes. Sometimes the dominant society is blamed, sometimes bad enviornment. Society in turn may choose to hold the individual responsible for controlling his or her own behavior, ultimately to hold individuals accountable no matter what kind of excuses they may have for their actions and

no matter what ethnicity or other exception they may claim. As the old saying goes, "where you stand has a lot to do with where you sit," and right now I'm in the Office of Minority Health. Though I have a long history of being in academic institutions, at this point, I have something of an anti-intellectual view of this problem. I just want to do something that works. Partly this attitude has been shaped by my experiences in various urban emergency rooms, one of which in particular comes to mind. Chester, Pennsylvania, is a small city in which, over the past decade, industry has died. Chester is an interracial, poor city. Working in the emergency room in Chester, what I saw was not really white or black; you couldn't tell the difference if you closed your eyes, listening to the stories. People, not races, were coming in, locked in combat, with lacerations, knife wounds, stab wounds, and so forth. I think this teaches us that we have to look at violence perhaps not as minority excesses but as an American problem.

William H. Foege, a former director of the Center for Disease Control, said that public health is in the business of redefining the unacceptable. We no longer can accept violence. We need to attach a stigma to violence as we have done to cigarette smoking. Smoking is no longer cool, and that has happened in a fairly short period of time, through the efforts of the Surgeon General and others. We have to do the same thing with violence. I think that a simple but straightforward message is important, something like the drug message, "Just Say No." I think it's critical that we try to take that kind of approach because otherwise we get all boxed up.

Our office has been involved in a number of things related to getting the issue of violence launched. One of them is to support conferences such as this one, and certainly we plan to support others. Given all the various channels of communications, it is important that opinion leaders like yourselves try to get out the message that violence is not okay; that it is not cool to respond self-righteously to assault or perceived threats or slights.

Because we felt that we needed to do something a little different among the minority communities that often don't respond to the customary channels of communication, we organized a grant program this year to support community institutions that come together in coalitions to try to reduce risk factors. The grants that we supported were directed at the risk factors for all of the six excess-death causes that we mentioned earlier, including homicide. We hope to continue to try to get minority communities to organize themselves, to empower them to deal with these issues. Obviously risk factors include other things like smoking, alcohol abuse, obesity, but also violence. Another thing that we've started to do is to meet with other components of the Public Health Service such as the National Institute of Mental Health, the Center for Disease Control, and the Office of the Surgeon General to plan a national antihomicide campaign.

A number of sites offer us opportunities for homicide-prevention education. Deborah Prothrow-Stith has launched a model effort in the Boston school system that teaches kids how to resolve conflict without escalating into violence. I think the school system is a good place to reach the kids. Thus, education is one site that we can use for prevention efforts. Another is community organizations such as churches, sororities, fraternities, and municipal government. We need to get out the message that when people see conflict, when people see kids scrapping, that they should intervene. Violence

shouldn't be acceptable. The idea that low-level violence and conflict lead to high-level violence and conflict may be a difficult issue for some of us, because clearly there is a need to jockey for one's position in the world, but I think that this jockeying doesn't have to be as lethal as it is in America.

There are two other places that I think offer opportunities for intervention: the medical-care system and law enforcement. The hospital emergency room is an excellent site for both homicide- and suicide-prevention efforts. The point has been made that if someone comes in threatening suicide or doing something self-destructive, there is a relatively low level of response inherent in our health-care system compared to our response to threatening or destructive acts towards others. We need to change that. We need to think about the fact that people often talk about things before they actually do them. In some cases, they may even be asking for external control. Law-enforcement officers also have a great opportunity to do this kind of prevention. Officers are often called to break up disturbances, family disputes, domestic quarrels, and there has been some suggestion that incarcerating husbands who beat their wives, even for a brief period, has a deterrent effect.

Now, I'll pose a question to you that I don't know the answer to. If we think of this kind of behavior as case-finding, what do we do about cases that we find? Violence is not a disease in the usual sense of the word. I'm not sure exactly what we do about people that we find engaging in violent behavior which may not be criminal in the usual sense of the word. I leave that to you to wrestle with. The final take-home message is that we really do have to initiate change. This change has to influence not only the pople who are dying but also our sense of social glue; the glue that holds us together. There have been a number of articles in Washington papers recently about how black males, especially young black males, are viewed with suspicion. There have been several instances of people who have called the police simply because a black male was shopping in the store. I think that this is true not only of white shopkeepers, but also of the black community in the sense that it is afraid of itself. The same is true of other minority communities. This shows that our attitude as a society is not only destructive with regard to life, but also with regard to social harmony and trust--bonds that we need in order to work together for other issues. I hope that we can do something to promote this "Just Say No" to violence. Thank you.

Luncheon Address

Violence as a National Health Problem

Luncheon Address — Faye G. Abdellah, R.N., Ed. D., Deputy Surgeon General, U.S. Public Health Service

Introduction — Roger Bulger, M.D., President, University of Texas Health Science Center at Houston

[Dr. Bulger explained that Surgeon General C. Everett Koop had to cancel his planned address due to emergency hospitalization. After commending the Surgeon General's taking a leadership role in dealing with the question of violence, he introduced Deputy Surgeon General Faye Abdellah.]

Dr. Faye G. Abdellah: Dr. Bulger, honored guests, friends. Today I will bring you Dr. Koop's message but it's also our message, one that's very important to all of us. Dr. Koop is with us this noon in spirit and in thought, and he is doing quite well. We do commend our prayers to him for his continued recovery. Before I get into his formal remarks, he did want me to specifically mention two things.

First, this kind of conference doesn't just happen. It comes about because of people and their contributions, and there are three people who have made this conference possible. My colleague and nurse friend, Dr. Annette Zimmern, has been working on this for months, identifying leaders like yourselves who will have a chance to work with us in the various workshops. Dr. Robert McGovern has been another great leader and person who has worked with us in this capacity. The third person is Ted Cron. I want particularly to recognize these three individuals for their efforts and continued work. There are also a lot of volunteers who worked on a number of these projects and many of you are here devoting your time and also your work at home. Dr. Koop feels that the program is outstanding.

Second, Dr. Koop believes violence is a public-health problem. He feels that violence has had a measurable impact not only on the physical and mental health of individuals but that it also involves citizens at every level in clinics and emergency rooms and other health-care facilities. Over a long period of time the most effective efforts in violence prevention will be generated by health professionals working together in the health fields. I feel as a nurse that this is an area where nurses can make a great contribution in solving some of the problems. It is clear that violence is an issue for all America. This Southwest Regional Conference is the first really major effort to give us a chance to look at some of the issues and what needs to be done. There is not a single compelling answer to the various complex questions related to violence.

We all know that the statistics in this area are very weak. There are estimates of about 4 million of our fellow citizens who are victims of violence and it is agreed to be a

minimum figure. Among these 4 million people are our most vulnerable citizens, children and the elderly. As a final and a bitter irony, almost all of these individuals are victimized in the privacy of their own homes. There are many hidden costs in dealing with the complexity of this problem. Victims of violence themselves absorb billions of dollars in emergency medicine and in long-term physical and mental-health care. The costs of the victims' court cases alone would run into the billions.

The seriousness of this problem has certainly raised it to the level of a public-health issue. Unfortunately, most people working in emergency rooms or clinics or practice areas have not been trained to handle the kinds of problems presented by victims of violence. If we want to improve the services to victims we must find ways to quickly improve the level of professional care now available to victims. One way is to develop new, more precise rigorous resource material for those in health and social-services staffs of all the health professional areas. A new manual has recently been prepared specifically for the use of nurses who are involved in caring for battered women. It is being published by the Women's Shelter of Greater Pittsburg and will be available this month.

Dr. Koop feels very strongly that we need to make information available to victims in ways which are meaningful and understandable. For example, his recent report on AIDS, which is directed at a sixth-grade-level education, has brought about tremendous response. We need to make resource materials available to the victims of violence in a similar manner. A second way of getting information out that Dr. Koop suggests is convening meetings such as this, regional conferences, sharing the word, communicating, and sharing information through linkages, through networks.

Several months ago Dr. Koop asked for a copy of a study done by researchers at the School of Nursing at Texas Woman's University. Of more than 200 pregnant women coming in for prenatal check-ups, 36 percent had experienced some form of spouse abuse or had been threatened with abuse. This is not surprising and not new information, but what does amaze us is that not one of them had been asked "How's everything at home?" by their attending physician. A very simple question, and if it had been asked, it might have opened up the floodgate to reveal their concerns about the problems at home, the battering that was going on, and other forms of violence. But nobody asked, and the women did not volunteer this information. Dr. Koop sent a copy of this study to the American College of Obstetrics and Gynecology with a cover letter indicating the importance of sensitizing members of this profession to the importance of violence and dealing with battered women.

A second way to begin the process is to establish more channels of communication and collaboration among personnel of health, law enforcement, and social-service agencies. The whole area of elder abuse is one which I feel is much neglected. In 27 states the law says to report elder abuse to the state human services agency; in 17 states elder abuse reports go to local law enforcement agencies; and in 14 states, including Texas, reports of elder abuse are directed to local human services agencies. If there is communication among these states, it is not obvious, and I think we could do a great deal about making recommendations in this area. Fortunately, both the Public Health Service and the Department of Justice would like to deal with this dichotomy. For the first time the two branches have jointly begun a law/health initiative on domestic violence.

Their first project deals specifically with the problems of child sexual abuse. This crime is one of the most shattering to comprehend. Children, some not more than infants, are used as objects of sexual gratification by an older person, who may be a parent, a sibling, or another member of the household. The result is a human catastrophe, with long-term trauma and effect upon the child as he or she grows up. We know that this is not new. The Kinsey report as early as 1953 reported that 25 percent of all females under the age of 14 were sexually molested or abused. One of the first activities of this project will be the development of generally accepted protocol for handling victims of child sexual abuse. The protocol would respond to both the victims' immediate need for treatment and the state's long-term need for evidence to prosecute the abuser. Much of the work will be coordinated with the American Academy of Pediatrics, and activity has already begun under Dr. Koop's leadership. The second project, the law/health initiative in family violence, will bring together in a series of meetings experts in law, health, and social services to identify precise ways in which these groups can collaborate and expand cooperation.

Now in closing, I quote Dr. Koop: "There is a new realism about criminal violence. We're looking more closely at the plight of each individual victim and we're rearranging, reorganizing, retraining, and redirecting our whole thinking in the way we deal with violence. If we succeed, then it's possible that fewer women, children, and old people will be brutalized by violence. This would be a commendable goal." Thank you very much.

Symposium

Violence as a Special Health Problem for Minorities

Moderator	Everett R. Rhoades, M.D., Director of Indian Health Service, U.S. Public Health Service
Panelists	Fernando A. Guerra, M.D., M.P.H., Pediatrician, San Antonio
	Joseph D. Little, LL.B., Judicial Services Officer, Bureau of Indian Affairs, U.S. Department of the Interior
	Ronald E. Cowart, M.A., Community Relations Officer, Dallas Police Department, East Dallas Community--Police and Refugee Affairs Center
	Ruth E. Dennis, Ph.D., Professor of Sociology, Meharry Medical College
Recorder	Wekota Crowghost, President, North American Indian Women's Association

Dr. Everett Rhoades: The six major problems that are unevenly distributed in the general population, with an undue percentage of victims being minorities are 1) cancer, 2) cardiac distress and stroke, 3) diabetes, 4) homicide, 5) accidents, and 6) infant mortality. He mentioned that 43 percent of the homicide victims in the U.S. are black and the majority of American Indian deaths are caused by accidents.

Dr. Fernando Guerra: I'm a practicing clinician with the experience of working in both the public and private sectors. My forte within the broad arena of pediatrics has been the care of children with complex illnesses, but I have spent time taking care of children and working with families in which there have been significant incidences of violence, abuse, neglect, exploitation, and victimization. When I was chairing the Community Health Services Committee for the American Academy of Pediatrics, I had the opportunity to look at child health needs along the U.S./Mexico borderlands. In some counties of New Mexico and Arizona I found an unusually high incidence of premature death among young Hispanics, in particular those that were engaged in seasonal farm work; and it was said to be related primarily to "accidents" or to supposed "accidental injuries." This stood out suspiciously ten times higher than the other reported causes of death. In some communities, the adolescent and young adult Mexican American or Hispanic male probably is leading any other population subgroup in terms of being a victim or a perpetrator of some

form of assault, homicide, or violence. I have found repeatedly that young adult males have not learned the art, or the skills, for being able to negotiate and to communicate. Maybe the difficulty resides in the epic history of the Mexican American, and much of it probably results from the machismo attitude and lifestyle.

When a premature infant is dismissed from a high-powered neonatal intensive care unit to go back home to impoverished circumstances, substandard housing, and poor living conditions, it is such a paradox to those of us who have seen the pattern of abuse and neglect that often follows. The gulf between what our health-care system today has the capability for doing to assure the survival of a population of young infants and our society's inability, at the same time, to provide other crucial resources present an intolerable paradox that must be addressed.

We hear that the Hispanic community is overrepresented in the homicide statistics. There is no infrastructure in place to do anything about effecting change so that this community continues to be underserved. It is underserved, in many instances, perhaps because of the lack of access to a sensitive health-care system.

Deputy Surgeon General Faye Abdellah says we need to ask "So how are things going?" "What is going on right now?" I agree that this is crucial, but if one can't ask it in a way that is culturally relevant, then one turns off the recipient of that kind of care. There are some special concerns within the Hispanic community because of the increased demand for services in parts of the country that are already, at times, significantly deprived, and that lack the kind of support and economic resources and the development for some things to happen. With the pattern of migration that continues to take place, in particular within the southwestern United States, this imposes a tremendous demand on limited resources. I think within the health-care system we have tremendous challenges, responsibilities, and opportunities. As physicians, nurses, administrators, social workers, case aides, we have that opportunity to interact with individuals in a way that provides us with information that we can use to help avert violence.

One of the things that we have observed repeatedly within the community, and I suspect that this is especially true of a population subgroup that has a higher incidence of violence and homicide, is that there seems to be a tendency in many instances to seek revenge. As I mentioned it is important to try to recognize the subtle indicators that perhaps place an individual or a family or even a sector of the community at risk, and we do that by asking more than the routine questions in our history. I think it's important also in our area of responsibility to know what opporunities that family has or that individual has for staying healthy. So many of the families that are within the descriptive category of being at risk or of having suffered abuse and some victimization do not allow themselves the opportunity for leisure time and for getting away from it all. A suggestion for a short-term intervention strategy that may have hope for at least bringing respite to some families is the bringing together with the health-care system of representatives from the educational system, the social welfare system, child protective services, and the judicial systems whenever one is dealing with a family. Granted, all of these things take time, but somehow we need to find that time.

[Dr. Rhoades introduced Joseph Little, Branch Chief for the Judicial Services for the Bureau of Indian Affairs, which provides a support service to the courts of federal offense and tribal court systems throughout the country.]

Mr. Joseph Little: Violence on the Indian reservation has been vividly with us even from the first flickerings of silent movies and the advent of the TV western. However, reality can seldom be adequately reflected on the large or small screens of our Americana. Currently, young Indian men are killing themselves at a rate at least twice that of the non-Indian population. National suicide rates among Indians have ranged from 14.7 per 100,000 in the early 1960s to 28.2 per 100,000 in the late 1970s while comparable figures for the population in general have remained steadily around 12 per 100,000.

Violence on the reservation has traditionally been related to alcohol abuse. There is still a large amount of violence within Indian country due to alcohol abuse among both young and old. A more recently identifiable area of concern is a growing violence aimed at children in increasing cases of child abuse and neglect. In the Indian communities there has for years been a kind of defensive mechanism in dealing with violence. Violence in some ways was a way of life with us even growing up. I'm not saying that we had bodies strewn all over the place, but there was a lot of violence in almost every reservation you went to. There are a lot of factors and reasons for it, everything from alcoholism to low employment. I used to represent a reservation that was as small as 170 people. In most of these areas the communities are tightly knit. People tend to know each other, to be related to each other. Within these settings, when violence occurs it is not isolated, but a community affair.

Each of the 147 tribes we service has its own judicial system, and these systems all deal with juveniles. Our Indian population on an average is almost 50 percent under the age of 25, but in my dealings with the tribal court systems over the years we seldom looked at children as victims. A lot of our work is taking care of the perpetrators, people who commit violence in any situation. For many years this violence was usually acted out among people 25 and over who had drinking problems or family problems, and the general trend was violence to each other or to themselves. On one occasion we had a child sex abuse case that the judge wasn't quite sure how to handle. We took custody of the child and began looking into the situation. We gained information in bits and pieces, from social services, Bureau of Indian Affairs (BIA), social services, health social services, Indian Health Service, county police departments, and bureau police departments. We had to assemble data from all these sources even to develop a case against the alleged perpetrator of the sexual abuse. Tribal areas--reservations--under federal law are distinct sovereign governments except where limited by Congress or special federal acts or an act of the Supreme Court. Thus, on many reservations a state doesn't have jurisdiction to enforce its laws. The federal government has a list of major crimes that the perpetrator can be charged with if the crime occurs on a reservation, however, until recently child abuse was not one of these. Soon after I arrived in Washington, D.C., we testified in favor of a bill that had been proposed and in which child sexual abuse was made one of the major crimes under federal law. Now a person committing that act on an Indian reservation can be cited into federal court. It's quite

difficult to deal with because you don't just have a perpetrator, you also have a victim and that victim is in need of as much care or some decision from the court as a perpetrator. So it's a new facet you have to look at, you have to identify the needs of everybody, not just the one committing the crime. Now you add to that the fact that you have a child who has been abused in a home situation and you can't remove the abuser. In a small tribal situation or even in the larger ones, often you can't put the child in an extended family because then everybody becomes aware of the situation and rather than support you, you might actually be disruptive. So it was decided to have the tribal government take jursidiction over these children and have them referred back to the Indian reservation rather than being referred to outside homes for adoption and foster care. The reversal of that is now we have situations where you have children who need to be taken out of the area but the mechanisms of the law don't allow for it. So we have some real strange situations occuring. The bottom line is that we have a number of jurisdictional areas now that we have to deal with. We have tribal jurisdiction, which is in some areas limited, we have state jurisdiction, which sometimes can get involved in it, and we have federal jursidiction. Now the problem is growing. We still don't have very accurate statistics on cases of negligence and child abuse on the reservation. We have the Indian Health Service and the Bureau of Indian Affairs through social services that take a certain amount of statistical information. But there is no unifying system for acquiring the information so that many of our records are skewed.

Dealing with perpetrators of crime on a reservation is extremely complex. I recall an instance in which a child died from abuse. Yet it was known within the community, even by officials, that abuse was going on. The parents had been arrested on a number of occasions for different things. It must have been obvious that the child was endangered, but it was never acknowledged until the child died.

Because of the relationship Indian tribes have with the federal government, we have a number of support services on the reservation. The Indian Health Service and the Bureau of Indian Affairs social workers operate within the reservation. We have both tribal and Bureau of Indian Affairs police. Some areas have a reservation boarding school. If there is no reservation-based school, the school may be off the reservation but supported by federal funds so that Indian counselors are located in these schools. But although we have these services, none of them are being integrated very well, so that children who are being abused are not really being provided the services available.

Let us look at what happens when a child in an off-reservation school gives some indication of abuse or neglect. A counselor who is working with the child discovers an obvious abuse situation. Ideally the counselor would bring in Indian Health Service who would give a physical examination, perform some psychiatric evaluations, and refer the case to its social services representatives. The Bureau of Indian Affairs would be immediately contacted; they in turn would contact the appropriate tribal officials and representatives and maybe in some instances county services. The legal system would review the case to determine whether the courts need to be involved in protection of the child, bringing charges against the perpetrator, or by court order directing treatment for family members. If the tribe doesn't have the facilities for child placement or ongoing

treatment for perpetrators and family members, county or state facilities should be able to provide these services.

Now that's the ideal situation in which a number of services and people pull together to work with the family in dealing with the issue, trying to preserve family structure while working as a unit to identify that there is a problem that must be resolved. We found, however, that generally none of these groups or very few of these groups pull together in that fashion. A psychiatrist who has important information may be afraid to release any of it for whatever reason. Sometimes it's for fear of being sued. Social workers working with a home environment situation wherein the child might need psychiatric help may never get in tough with IHS or other facilities that could provide it. You have county or city governments arguing with the tribal governments back and forth about who is responsible for the child. As we go through the cyclical argument of who is supposed to provide the services, the child stays in the home and continues to be abused. Some of the court systems can't identify an abuse situation, for as I stated earlier, it's very difficult to get sufficient evidence to prove a sexual-abuse situation.

We have taken a signficant step, on a national level, in dealing with the fragmentation and disunity I have described. Dr. Rhoades and Mr. Swimmer, undersecretary of the Interior for Indian Affairs, have entered into a broad memorandum of understanding intended to allow the Indian Health Services and the Bureau of Indian Affairs to work together in such areas as education and social services rather than working in isolation. In line with that, I have been working with a task force made up of members of the Indian Health Service, Bureau of Indian Affairs police, Bureau of Social Services, Health and Human Services, and the judicial system to put together a set of criteria that would establish child-protection teams in area offices of IHS and BIA throughout the country.

When I was growing up, the interest in protecting our children centered in the area of education. Our tribal leaders believed that if they could get all the children educated, then all the problems would be solved. The resources we had other than in education tended towards servicing adults. Our sense of priorities is changing, but the thing that I think has been missing is that we haven't gone and looked at the beginning of the cycles of violence especially evident within reservations systems. The children running around the community I grew up in were not isolated members within that community. From the elders to the warriors to the mothers, everybody had a hand in raising children, not just their own children, but all the children, because the children were the hub of the community. I think we need to go back to that in some form, in terms of having a number of the agencies that have been set up to provide services to us to do so in a more coordinated fashion, with fewer turf fights and more direct involvement with the child, looking at the child as the ultimate goal in the services that they're providing. I hope that our new bureaucratic approach will succeed in doing that, but I also hope that we will get support from the local communities. The problem can't be approached in an isolated fashion.

[Dr. Rhoades next introduced Ronald E. Cowart, an officer in the Dallas Police Department and Vietnam veteran who helped to create the East Dallas Store Front, an office

serving as a cultural liaison between the city and recent immigrants from Cambodia, Cuba, Laos, Vietnam, Mexico, and Thailand.]

Officer Ronald E. Cowart: I'm going to talk to you about the impact on Southeast Asians of the criminal justice system. I have a police store front, the first of its kind in the U.S., in the area that we call Little Asia. I'm going to take you through the world of Ton Win. He's an Amerasian. I've interviewed and talked to more than 100 Amerasian children. They are some of the most tragic victims in the refugee experience and I'd like to take Ton Win through the criminal justice system with you.

Ton Win's father was a G.I. who met his mother in a Saigon bar during the war years of early 1960. She almost lost her life during a painful delivery in the upstairs room above the bar where she earned her living as a part-time prostitute. Ton began this life among the clutter and dirt of a lonely dark room and confusion of a war-torn country. His mother hated her job as a bar girl and especially as a prostitute, but she had to make a living and this was the best she could do. She had two very good reasons for hating this child; the pain that almost took her life was matched by the horror when she saw her baby for the very first time. The baby was black. He would be a daily reminder of what she was and how she hated it.

When the Communists took over in 1975, she quickly took allegiance to the new government, informing the state that she had been a victim of rape by an American soldier. As for all mothers of Amerasian children, the new government reduced her food rations by at least one and she took a job as a street sweeper while she waited for possible judgment against her by a vindictive country. To supplement her meager earnings, she forced Ton to join the hundreds of other Amerasians standing on the various street corners selling apples and pencils. Vietnamese and Russians alike would often hit or kick the little Amerasians.

In 1985, Ton's mother finally succeeded in emigrating to America, and she and Ton and her four other children settled in Dallas. Sixteen years old, Ton was enrolled in the seventh grade. Unable to speak any English at all, Ton found himself the object of wide-eyed stares in his all-English-speaking classes at the neighborhood junior high school. But he was dressed in the new blue jeans and white tennis shoes provided by his sponsor, and he had hopes of blending in with the other American kids. But when he spoke, he drew laughs from all the other students; and even the Vietnamese who could understand him were embarrassed at being associated with this strange member of two races. The kids imitated his speech with a sort of sing-song gibberish or pulled their eyes into an exaggerated slant in obvious ridicule. Ton fought to control his emotions the same way he fought the pen that he had never held before in his life. He nervously rolled the pen about until he had marked all over himself to the great amusement of the other students. In fury, Ton finally threw his pen to the floor and walked out of class. He was brought back.

The hopelessness and isolation made Ton more and more unruly. His teacher gave him a big "F" in bright red across the front of his test paper and told him to go home and get his mother to write her signature under it. "You're oriental", she told him, "Orientals are very smart, I want your mother to know that you are not applying yourself and maybe she can knock a little sense into you." And his mother did. A feeling of hopelessness and

despair among many parents of Southeast Asian children, causes them to place a heavy burden on their children to excel in school. It is the hope of these parents that their children will finish school and to go to college, find professional employment, and then take care of their parents. If the child is a failure, then there is no hope for happiness and security. Punishment is quick and severe. Ton received dark and painful bruises about his face for the failure received on a test he could not understand.

Homework is extremely difficult for refugees who often live in one-bedroom apartments with little or no furniture. Eating and sleeping are often done on the floor, and the average number of people living in this tiny apartment may run as high as fifteen. Daily household chores such as cooking, sewing, sweeping, ironing, and babysitting are usually done by the children before they are even allowed to do their homework. Many like Ton will sit long hours and study words and letters they don't understand. They often receive miserable grades for efforts few realize.

Ton's mother usually awakened him before sun-up to get him out of the house to search for cans so that the elders could beat and flatten them for selling, the only way the rent could be made. She often found Ton asleep with his head over his schoolbooks and tear-stained papers. It was while he was gathering aluminum cans that he realized that his life held nothing for him. He would always be an outcast, unable to learn English, unloved and ridiculed. He made up his mind to run away.

While Ton was sitting on the steps of his apartment in the "Little Asia," a brand new, bright red Camaro pulled up in front of Ton's apartment. Up from this sports car walked two neatly dressed Vietnamese boys who could not have been much older than Ton. They approached Ton and sat down beside him. They told thim that he ought to be in school. Ton said that he was too stupid to go to school. The youths told him that he was indeed stupid. They told him that they had grown up as orphans in refugee camps, having watched their parents die in the camps. They told him they too were unloved and uncared for, that they could not go to school, that no one even cared enough to come looking for them. As Ton wept, they told him that they would give him the things he dreamed about. Ton would finally become important to someone. His new friends brought him clothes. They drove him around in the bright, shiny Camaro. They fed him good food and gave him a gun and thereby a sense of power. He learned to rob and to use a knife as well as a gun. The more vicious he became, the more respect he received from his new friends. He even started his own gang. No one threatened him anymore.

Ton robbed only his fellow Vietnamese. He knew that no one would dare call the police; he knew well the severe language problems that kept the Asian refugees from being able to communicate anyway. He knew that when a knock comes on a door in this neighborhood, people will sit and whimper and even huddle in a corner in hopes that the intruder will go away. Ton Win was responsible for more than a dozen robberies in the Dallas/Fort Worth area. Many were not reported, but a Cambodian refugee family walked over a mile from their apartment to the home of a police public service officer to tell him of their ordeal. They did this for one reason; he too was Cambodian. Pso Po Tai is the first fully police trained Cambodian officer in the United States. Because Pso Po Tai was able to gain the confidence of his people, Ton Win was identified and subsequently arrested.

Several thousand dollars worth of stolen electronic equipment was recovered. Ton still doesn't realize the cooperation that has been established between the police and a community that has both a fear of police and a language barrier.

Ton represents the truest tragedy of the refugee experience in America. How we as Americans, especially service providers, treat and understand them now will reflect on how well they become good, useful citizens of tomorrow. An immigrant comes to America looking for a better way of life. A refugee can never go back. He cannot even be deported. We must accept the fact that as long as we represent ourselves to be a beacon of democracy in these dark and troubled times, we will continue to draw immigrants and refugees. Thousands of refugees are born in camps where murder, robbery, and other forms of violence are a natural way of life. Children see their families murdered or watch them die from starvation or sickness. Many teenagers are illiterate in their own language when placed in school for the first time in their lives, so many drop out of school. Many Asian refugees are arrested and are unable to understand the reasons for their custody. Food and welfare offices across the country do not have translators or forms available in their clients' languages. Children in our schools are often denied lunches simply because of language difficulties. Too often we hear that Asians are smart. They don't need help. We don't see the high drop-out rate, the crumbling home life, the high alcoholism, gambling, and the wife- and child-abuse in the Asian refugee community. We don't see the mental illness associated with loneliness, depression, and the heartbreak of having had to watch their loved ones being killed by one of the most brutal regimes in human history.

The Police Department has established a donation-funded police store-front in the heart of the area known as Little Asia, a 1-1/2-square-mile area containing an estimated four thousand Southeast Asian refugees. It is also the most ethnically diverse area to be found this side of the United Nations itself. Central and South Americans--including Salvadorian, Cuban, Peruvian, Ecuadorian, Mexican--along with Ethiopians and Eastern Europeans share the turf with Asians and Americans. Each group came to America under a different set of social and economic circumstances; therefore, each will adapt to the host country in a different way. The purpose of the store front is to identify the cultural and language barriers that may prohibit access to the systems we Americans take for granted. A successful job-referral system is in effect. Programs for non-English-speaking children, are coordinated through the Parks and Recreation Department. Crime prevention programs are conducted in four different languages. Four Boy Scout troops and a Girl Scout troop regularly meet and are sponsored at the store front. Mediation and family counseling are part of the store-front operations. Our personnel are multinational: Po Tai is a Cambodian; Lek Ku Veli is Laotian; Tao Dom is Vietnamese; and we will have a Hispanic on board within the month. They are graduates of Dallas police training and are assigned to the store front as public service officers. They have the respect of the community who call upon them frequently. We are dealing with people, cultures, traditions, and languages alien to anything we've ever known before. As I said before, it's how we treat them now that will determine whether they are going to be good, useful citizens in the future. The latest census predicted that by the year 2000 orientals will be the number two minority in the United States. So there is a lot of work to be done.

Dr. Ruth Dennis: Frustration, anger, poverty, or whatever causes homicide must impact the black population more than anybody else, for almost half the homicides committed in this country are committed by the black population. Those of us who are concerned with this are caught up in a cycle of violence that overwhelms us. But we know that homicide is just one of the forms of violence that takes the lives of black people. If we include accidents, suicides, cirrhosis of the liver, and other self-destructive behaviors, most black deaths in America are from violence. The black population has been involved in violence every since the days of slavery. I wanted to create a present-day profile of those who are at high risk to homicide, and to take a little stab at suggesting what is causing it and how it can be prevented. The data for this analysis are taken from several of the established places, especially Vital Statistics, Center for Disease Control, and FBI uniform crime reports.

The period between 1960 and 1983 saw some dramatic changes in the black homicide rate. The black male homicide rate of 36.6 in 1960 increased to over 70 in 1970, continuing a slight increase until 1974 when homicide peaked in this country for blacks in general. Starting in 1980 homicide seemed to be decreasing in this population for the whole first half of the decade. The decrease in the homicide rate in the black male as we are noting it today, is seen where the earlier greatest increase was--between ages 20 and 25. The very sharp increase that we saw in the decades of the sixties we think may be matched now by a very sharp decrease or reverse in the eighties. We are taking a wait-and-see philosopy on that since preliminary data for 1985 in a July press release show that homicide may be increasing again among blacks.

The South traditionally shows a higher rate for blacks that do other regions of the country. However, our 1980 vital statistics show that the trend has shifted to the western region. The homicide rate in 1983 was lowest in the South for blacks for the first time since these statistics have been reported. Despite these changes, 47 percent of all black homicides are committed in the South. Fifty-three percent of all blacks in the country live in the South. The states that account for the most homicides include Nevada, California, and Utah. Nevada shows the highest homicide rate for all the states in 1980. We think that we have to look at the populations in Nevada and Utah, which have very few black inhabitants, which may account for the very high rate of homicide there. In fact, all of the states in the western region have a low black population except California, where 85 percent of all the black homicides in the western region are committed. Of course, 80 percent of all blacks in the western region live in California. The cities that have the highest homicide rate among blacks are Detroit, Gary, Richmond, St. Louis, New York, and Dallas. Three of the cities that rate in the top twenty states are in Texas, namely Dallas, Forth Worth, and Houston. The state of Texas in 1980 ranked ninth in black homicide. Michigan's Detroit and Flint rank first and eighth in the top ten in black homicide.

Homicide continues to be among the leading causes of death for black men between 15 and 34. The rate is still highest in the 20 to 29 age group, for whom it is the leading cause of death. Black men between the ages of 15 and 34 accounted for 61 percent of the total homicide deaths in 1983 and 58 percent of black female deaths in that same age group. The sharp 60 percent decrease in homicide that we have been witnessing since 1980 is in

the 20-24 and 25-29 age groups. The median age for homicide victims and blacks has continued to become younger since 1970. The median age was 31.7 in 1970 and 30.4 in 1983. During these same years, there was a slightly younger age for black females too, 31.2 in 1970 and 29.1 in 1980. There was a total of 4,627 deaths due to firearms in 1960 representing 54.7 percent of the total homicide rate that year. The number increased to 13,572 in 1973, representing 67 percent of the homicide rates that year. In 1983 firearms continued to be the primary means of homicides for blacks. But during this time, there was a decrease in this method for whites too, from 60 to 57 percent. Homicide by means of firearms increased for other races. Cutting and piercing remained the next highest rate for homicide.

Homicide continues to be primarily an intra-racial affair, that is black on black or white on white. In 1983, more than half the victims knew their assailants as a family member, friend, or acquaintance. The percentage of assailants known to the victim, as reported in 1983, is highest among the black population (58 percent). Examination of trends in the black population using the sources of data noted before shows that the black male at highest risk is about 30 years old. He lives in a large urban area, probably Los Angeles, Dallas, or Detroit. It is highly probable that he will be killed with a handgun by someone he knows. The high-risk profile for a black woman is similar except that she is likely to be a bit younger and her assailant will probably be her spouse or boyfriend. From the literature and from some research that we're doing at Meharry, in which we're looking at victims, perpetrators, and their controls, we could add to that profile. The victims would be undereducated, probably unemployed, would be substance abusers, carry a weapon, and have previous arrest records. They are likely to have been the aggressors and in some way to have participated in their own victimization. A black female often participates in her own demise by not being able to assess accurately the life-threatening situation or by agitating the assailant. The perpetrator has a similar profile but does not have an aggressive history. He has an even lower education level than his victim and would be classified by sociologists as a retreatist.

Despite all the homicide research I have just cited, we are left with a question: What is responsible for the declining rate that we have observed in the first half of this decade? Several factors come to my mind that probably merit further analysis. 1) Adaptation syndrome for blacks. Could it be that the rapid cultural and societal changes that occurred during the sixties have either slowed or that the group most affected by those changes, the blacks, are beginning to adapt? 2) Change in the method of homicide since 1976. We saw a decrease in the use of firearms in homicide. We noticed that in 1976, 69.4 percent used firearms and in 1983 that had decreased, met by a subsequent decrease in homicide rate. Whether the reduction in the use of firearms as a means of homicide is due to changes in social norms or effective social or penal controls, this deserves special attention. 3) Substance abuse. Substance abuse and other sociopathological behavior may be alternatives to homicide as a stress-adaptation mechanism. The increase in rape, as well as other crimes, may be an alternative. We must ask ourselves, especially with regard to black males, have they found a new outlet for their pent-up frustration? One of the things that I've observed in Nashville is that 25 of the last 30 homicides in this city were drug related.

We may be seeing a change in the dynamics of homicide in the black population. The penal system may also be a factor in homicide-rate reduction. In the South, we have the highest number of people on death row in any part of the country. In 1983, there were 710, and 41 percent of the people under death sentences are black.

Still other factors may impinge on the etiology of homicide. We are doing three things to look at these other factors: 1) we have a program in which we're looking at victims of homicide admitted to emergency-rooms; 2) in another program we're looking at spouses and their children and trying to intervene in family violence; and 3) we're talking about empowerment of black men, which we think has an impact upon violence. In any case, we still feel that homicide rates are affected by unemployment, ambivalent value systems, and weakened social institutions such as church, family, and schools. These factors still remain areas of weakness, especially in the black population, and they require continued monitoring for effective prevention.

PART II

- ◊ Child Sexual Abuse
- ◊ Child Abuse
- ◊ Elder Abuse
- ◊ Spouse Abuse

Workshop

Child Sexual Abuse

Moderator	John Dyer, M.D., M.P.H., Assistant Surgeon General, U.S. Public Health Service, Regional Health Administrator, Region VI, Dallas
Panelists	Paul Prescott, M.D., Medical Director, REACH Clinic and Assistant Professor of Pediatrics, University of Texas Health Science Center at Dallas
	Carolyn Newberger, Ed.D., Research Director, Family Development Study, Boston Children's Hospital, Boston
	Larry Hebert, M.D., Professor of Pediatrics, Louisiana State University Medical College, and Chief of Pediatrics, Earl K. Long Memorial Hospital, Baton Rouge
Recorder	Pamela Ruthven, M.S.W., Graduate School of Social Work, University of Texas at Arlington

[Speakers were asked to discuss state-of-the-art research and available data.]

Dr. Paul Prescott: Conflicting data leave us with a question of how common or how recent child sexual abuse is. I would like to push for more well designed prevalence studies. Probably the best that can be done is to do a population survey with 18- or 19-year-olds and get some idea of child sexual abuse over the past decade or so. If you are dealing with an older population and if sex abuse has actually had a numerical increase, then your prevalence study is not going to show it. Differences in educational levels of survey respondents may or may not make a difference. One published study seems to suggest that sexual abuse is equally present at all educational and economic levels. Other studies seem to dispute that. Ethnic composition doesn't seem to make a difference according to most studies, but you will find people who believe abuse is more common in certain segments of the population. The way samples are put together can also affect these studies. Self-selected samples (i.e., prison populations, therapy groups, or individuals in therapy) are extremely biased sources of data. You are answering the numerator of the question, not the denominator. *These* women or men coming to us for therapy for sexual abuse have *these* problems. How many women or men who don't come to therapy don't have this problem? The way that you select people for a study is very prone to error also. If you are directing a study toward abuse, the nonabused people may feel they have nothing to contribute and won't respond, so again you are getting a selected sample. On the other hand abused people may not want to speak of childhood experiences. The methods of data

collection, whether by face-to-face interview or self-filled questionnaires, would obviously affect and have affected past studies. Face-to-face interviews or self-filled questionnaires seem to be the most reliable, but, again, the type of question used influences the answer. Broad questions may not trigger memories of a forgotten or repressed event from the past, and direct questions may cause people to repress something that they could remember.

The largest problem so far has been lack of a definition of child sexual abuse. Some studies include exhibitionism by a stranger at a football game which, though it may have been traumatic for the subject, could hardly be put in the same category with protracted abuse by a family member. Other distinctions that need to be made include whether the abuse involves contact or not and at what age to separate sexual abuse from normal adolescent sexual activity. Very few studies have attempted to define when a peer-to-peer relationship constitutes sexual abuse and when it does not. One attempt at definition has suggested that sex between adolescents differing in age by more than 2 years is abuse, however in my opinion, some 14-year-olds are capable of consensual sex with an adult and, although this may be termed sexual *misuse,* it should not come under the category of sexual abuse.

The same degree of confusion has existed with regard to the classification and identification of offenders, with pedophiles lumped into the same category as incestual and situation offenders and no age-group distinctions being made. A better taxonomic classification of offenders needs to be produced, especially for the purposes of treatment, which will obviously vary greatly among the categories listed here.

We need better communication among our research groups as well as a better classification system. The National Incidence Study of Child Abuse and Neglect came up with a figure of about 44,700 cases as a nationwide estimate of new cases of sexual abuse in a year, a figure so astoundingly low that there have been numerous articles written criticizing it. The data in that sample came only from professional sources, basically Child Protective Services and police sources. The identification of the perpetrator was limited to a parent or caretaker and the perpetrator data were extremely limited. Mothers were listed as perpetrators in 44 percent of the cases, which no literature sustains, because active perpetration by the mother was lumped with passive perpetration. When such figures are used in an attempt to define the problem, it leads to even more bad research.

There are many questions left unanswered by extant research. Are mothers aware that abuse is occurring. Are family break-ups an inevitable result of child sexual abuse? Different studies cite a "minimal" or "severe" psychological effect of abuse on the child, and current studies show that the family does not necessarily separate. In interviewing sexually abused children, most of us make use of anatomically correct dolls, yet nobody has used this technique with nonabused children, to see how they would respond, for very obvious reasons. We would run into ethical problems and we would have to be certain that the control group had not been sexually abused. The worst problem with these interviews is that they require a high degree of skill and training. We need better standards and better knowledge of what constitutes a normal course of sexual development. We need a longitudinal scale of how children develop sexual attitudes and knowledge.

From a clinical perspective, incorrect medical diagnosis and procedure is the most prevalent cause of our lack of good information. More research needs to be done on normal anatomy and on new investigative techniques, and more training in this area needs to be given medical personnel. Equally, improper case-worker and supervisor training can lead to improper referrals, improper therapy groups, all kinds of problems.

The second most prevalent problem with our data is reliance on correlation. Correlation is not proof and correlation is not cause. That a characteristic is found more often in a particular population should not be considered a tool of proof or diagnosis.

My recommendation to anyone who is interested in doing research in child abuse is to look into previous research. Make sure you have a rigorous definition of child sexual abuse, look into statistical standards of analysis, which are often violated, and be sure to report everything you find, not just the "cream of the crop" so that those who want to use your research can better evaluate it.

Dr. Carolyn Newberger: I would like to talk today about the study of stressful experiences in childhood. [Several minutes missing due to mechanical failure.] People differ widely in the ways in which they respond to a given experience, and the outcome of an abusive childhood is affected by a number of mediating factors.

The most common period for abuse, as far as our data reveal, appears to be when the child is between the ages of about 8 and 12. Survey data indicate that children who are sexually victimized do not differ from other children in race, ethnic background or education, but they are likely to come from socially isolated families, with lower incomes, and strict and conservative values with regard to authority and sexuality. The presence of a stepfather appears to increase the child's likelihood of being sexually exploited, as does the emotional or physical unavailability of the child's mother. Recent studies indicate that many persons who are sexually victimized as children do not grow up to be prostitutes, drug abusers, or psychiatric patients. This does not mean, however, that sexual abuse does not have enduring consequences. Numerous studies of both clinical and nonclinical populations have identified symptoms of psychological vulnerability and distress in adults who were sexually victimized as children. These include depression, anxiety, low self-esteem, work difficulties, vulnerability to further victimization, and substance abuse. We must remember, though, that these symptoms are also found in individuals with very different histories and in fact are epidemic in our society. It is difficult to determine whether the symptoms are a response to early victimizing sexual experiences or to other aspects of people's lives.

Studies of the initial effects of sexual victimization on children have identified a variety of symptoms frequently following abuse including generalized anxiety and fear, hypervigilance, specific phobias and nightmares, feelings of guilt and shame, somatic complaints such as fatigue, loss of appetite, headaches, abdominal pain, and changes in sleeping and eating patterns. Children may become withdrawn and their grades may drop. Some children become aggressive and hostile or may put on a front of sexual sophistication. Heightened sexual activity has been observed even among younger children, evidenced by compulsive masturbation, exhibition of the genitals, and

preoccupation with sex and nudity. Commonly noted in older children are truancy and promiscuity after sexual assault; running away from home has also been documented as a response to sexual victimization.

A few studies have examined differences in consequences of childhood sexual abuse as a function of characteristics of the abuse, the child, and the family. Many of these studies have very small samples and limited methodologies; however, when there is a convergence of findings of two or more studies, one can feel more confident that they represent real relationships. Some of the factors that have been found by at least two studies to predict more severe behavioral problems following victimization include the perpetrator's being male, adult, father or stepfather, experiences involving genital contact or the use of force, and lack of family support.

In a study of sexually abused children that was done several years ago at the Children's Hospital National Medical Center, one psychologist found that behavioral problems following sexual victimization were best explained by interactions between variables rather than one factor. Although lack of family support, male perpetrator, and the use of force were all independently associated with more severe behavioral problems in children, problems were more frequent for older children forced into sexual relations than for younger children and if force was used with the child in distant relationships. Additionally, older girls were found to be more affected by the use of force than were either younger or older boys.

If an individual is sexually abused as a child that does not mean that he or she is destined for difficulties as an adult. It may be that when a child is sexually abused, the response to that abuse by parents and institutions is as important as, or even more important than, the circumstances of the victimization on how the child will respond and whether the child will recover. It may also be that personal characteristics of this child, both developmental and psychological, may also be as important or more important in the recovery.

Dr. Larry Hebert: I'd like to talk about some of the problems in managing children that we think, or someone thinks, may be sexually abused. When we try to distinguish normal sexual exploratory behavior from sexual abuse, we have a real problem. I don't want to discourage doctors from becoming involved in sexual-abuse investigations; however, it is important to understand some of the things that can go on. What counts most when the case comes to court may not be the opinions of the specialists involved, but the testimony of the accused and the defendant. The issue in a case about which I am presently being sued was whether a certain behavior exhibited by a two-and-a-half-year-old child was normal or abnormal and should constitute evidence that the child had been abused. The testimony of myself and four other professionals was irrelevant to the judge, who found the exhibited behavior to be normal. I am still willing to put my professional expertise on the line, but I don't think a physician can ever say by just examining a child that there is no question that the child has been sexually abused.

I think we need to do three things; the first of which is to define our terms. The Department of Health and Human Resources developed a booklet called "The Role of the

Physician in Reporting and Preventing Child Abuse and Neglect." In this little book are up-to-date definitions of abuse and of sexual abuse and a statement of the role of a physician in the state of Louisiana. Department of Health and Human Resources (DHHR) has also published an attractive pamphlet entitled "Louisiana Report on Child Abuse and Neglect" that tells the public how frequent this is, what we are doing about it, etc. Another publication by the Louisiana DHHR is called the "Louisiana Child Abuse Project," released in March 1986. It evaluated how social workers, doctors, law-enforcement officers, judges, and others coped with the problem of child sexual abuse. As a result of this report 64 parishes (almost all) in Louisiana now provide access to a multidisciplinary consultation team to every child-protection service agency.

Another thing that is very important is getting agencies to work together. Interagency agreements have been made on many different levels of the communities, and these increase the level of interagency cooperation and communication. We now have state money available for contracting with doctors, lawyers, and psychologists. I don't believe that we can ask professionals to donate their time and not be paid for some of these very time-consuming things.

Finally, I think our efforts must be in education of professionals, training our residents, and getting them to work with us side-by-side, examine the children, go to court with us, and learn as much as possible better methods of identification, and, of course, work in prevention. I encourage our house staff to get involved at the community level, because the physician has a lot of credibility; people will listen to the physician.

[Moderator Dr. John Dyer stated that this session would include suggestions in the areas of practice and basic research.]

Dr. Carolyn Newberger: We have found that rather than victimization leading to a predictable outcome, there is a wide range of possible outcomes. We find that victims' lives have varying degrees of difficulty but can be repairable in early periods. One of the gaps in our understanding is the nature of the relationship between short-term outcomes and long-term outcomes. I have noticed from my work that although sometimes a child may seem to be coping effectively on a short-term basis, the long-term outcome may be very different. Victimization may cover several developmental stages of the child, and the intervention itself may be a time-consuming thing. It is important to attend to the child's needs over these periods to increase the likelihood of a positive outcome.

There are very few studies of sexual victimization of children that start with the developmental level of a child. Let us think of a child who is three or four years old and really doesn't have much of a say about what the rest of the world is doing with her. A child of that age knows about the world only what she has learned through her own protective environment. We need to understand the developmental context in which abuse has taken place in order to understand where the child is going right now. Cognitive variables, emotional variables, and situational variables all contribute to the way a child deals with the problem. It is important that a child feel that her world is controllable; the less controllable the world feels, the more traumatic the victimizing experience is for the

child. The environmental variables would have to do with the capacity of parents, capacity of peers, and their degree of sensitivity to the child's need. When a child appraises the environment as within his or her ability to change, that has an effect on the environment's capacity to respond to the child. Both the child's attributes and the environmental sensitivity are related to the kinds of coping behavior that the child will be able to initiate.

I have been asked about interviewing techniques. I will tell you about some good research measures which have been developed. These are not clinical measures, but they can get you to thinking about how you would like to do it. The locus of control measure was developed by James Connell at the University of Rochester. George Spivak and Leonard Shure have done some work on problem-solving thinking in children, and Susan Carter, University of Colorado, has done work on children's sense of their own competence and mastery.

I think we should keep in mind that we are part of the responding environment of the child. We can't approach problems by trying to formulate universal solutions; rather we should try to develop our perspective and our tools to take a sensitive, nuanced, individualized perspective on children and families. For me, one of the priorities is a child's sense of mastery. A child's basic stance in relation to the world--friends, school, being heard and understood--is absolutely at the core of human development. We need to pay particular attention to loss of trust and a view of the self as somehow damaged because of a sense of helplessness. Children can be given experiences in which they exercise control. They might write a letter to someone important in their life, help other people, participate in group experiences with peers which afford a validation of their own experience.

Dr. Paul Prescott: From a purely clinical standpoint, there are things that we need more basic research on. I think that in order to get a handle on the problems of child sexual abuse and child abuse in general, we do need better defined regionalized prevalence and incidence studies. One nationwide study with a standardized questionnaire agreed upon by everyone involved would be ideal. I would like to see more research on normal individuals and normal sexual development. I have seen a lot of videotapes and it amazes me sometimes what people will say proves sexual abuse. Children are curious about their bodies and sometimes explore them in bizarre ways. We don't know what a normal nonabused three-year-old would do with anatomically correct dolls. [a few minutes lost due to mechanical difficulties.]

We need better professional training, and I hope that will be set up soon, not just for doctors, but for caseworkers and anybody who is dealing with sexually abused children.

We need to assess risk factors too: what is it about a particular child that might make that child more prone to sexual abuse? Does the child's behavior in any way contribute to it? I happen to believe the answer to that would sometimes be yes, although that is no excuse for the offender.

My final recommendation is that we need sex education and family education in school, especially family-life education--balancing a checkbook and knowing how to work a budget as well as knowing where babies come from.

We will never do away with incest but we do need to understand it in more depth and try to develop programs that, while they may not cure the problem, will help more people than I think we are helping now.

Dr. Larry Hebert: I'm concerned that all of us are listening for magic answers on how we are going to take care of the sexually abused child. In my opinion, the sexually abused child differs from the child who has been physically abused in other ways essentially in that he or she has had a specific area violated. For five years we have been investigating cases, taking care of the children, and treating the children and their families, successfully in many cases; why do we have to spend another ten years waiting for some ivory tower doctor to come down and tell us what to do? Look around you and see what works, who has the most expertise in this area. The adolescents I see in the hospital have similar behavioral problems to those of other abused children; they are acting out in the same ways. Nothing magic is going to come from all this research.

Getting to the subject of data collection, we have already decided that we have to define sexual abuse, but I think it is very important that we define it in legal terms and in medical terms, because legally each state has certain laws that define sexual abuse, and we are going to have to be very clear as to what we agree upon. Deputy Surgeon General Abdellah feels that the surgeon general will come up with a national definition of sexual abuse. I think that would be very useful. I would also hope that the state that gets the regional data collection system grant would look at what has already been done by some of the other states and try to find out what works and doesn't work.

Another thing that the Surgeon General would like is for the Department of Justice and the Surgeon General to work more closely together. A written agreement is a very useful instrument of cooperation between agencies Our interagency agreement for the state of Louisiana says in writing to child-protection workers, district attorneys, schools, and law enforcement that when we have a case of child abuse we will work together, we will support each other, we will investigate together.

The other thing I think we will need to consider at the state and community level is the formation of special units to deal with the sexual abuse problem. I am suggesting that all child protection services have a sex-abuse unit.

Regarding medical examinations, I think our physicians need to be aware specifically of what they are expected to do, what are the latest protocols on how to examine children. The doctor will be a key person in deciding whether or not child sexual abuse is identified. We need to be very careful in writing our medical reports; it is a good idea to have a lawyer involved right from the beginning to help both physicians and social workers prepare their reports. I have also found that unless the doctors, child-protection service workers, and law-enforcement people meet to go over the case before the trial, it is usually not done right. We have to be very sophisticated in what we present today. Another thing we don't always think of is to have an advocate for the child, not just a lawyer to represent the child's legal rights, but someone who is trained in getting the child to testify and to be supportive of the child.

Regarding the success rate in 1986, I think we can say that the treatment success rate for the sexually abused child is much lower than that for other physically abused and neglected children, although people are doing very good work in various parts of the country. Prevention is a key area, and the media can be very helpful here. What we tell the media has a great impact on people regarding what we are doing, what should be done, and how they can contribute. Parent-aid organizations are good. We could not do without Parents Anonymous; we send a lot of our patients to them. Legislation is an area of consideration, we have to work very closely with the legislature, not only for funding but for changing laws appropriately as new information comes in. We have a Children's Trust Fund with contributions through income-tax check-off to be used specifically for prevention. A "first step" program is being designed for our facility by Parents Anonymous from a grant that they received from the Children's Trust Fund. Every mother who delivers a baby in the Baton Rouge community (about 12,000 per year) will have the opportunity to learn about parenting techniques and possible problems that they may find in parenting. Anyone who seems unduly disturbed by the possibilities can be counseled at that point, and I think this is very primary prevention. Research: we have to share with each other the successful programs and we need to share research findings early on so we can start applying them. Funding sources: I think the best organization in the best state, the most effective state, the most organized state should get the grant, but at the same time, we should work together.

Workshop

Child Abuse

Moderator	Lt. Col. Hank Vader, M.S.W., Director, Mental Health Clinic, USAF Regional Hospital, March Air Force Base, California
Panelists	Blair Justice, Ph.D., Professor of Psychology, School of Public Health, and Chairman, Standing Committee on Interpersonal Violence, University of Texas Health Science Center at Houston
	Jerry P. Flanzer, D.S.W., Professor, Graduate School of Social Work, University of Arkansas at Little Rock
	Eli Newberger, M.D., Professor of Pediatrics, Harvard Medical College, Boston
Recorder	Denise T. Clemons, M.S.W., Family Advocacy Program, Naval Air Station, Dallas

Dr. Blair Justice: Primary prevention programs, especially those that have controlled design and demonstrated effectiveness are showing a lot of promise. All these services are offered to new parents. Some of these are called lay health visitor programs, some are called parent aid programs. some are incorporated into larger programs, such as Positive Paranatal Parenting, a program developed in East Lansing, Michigan, by Dr. Bolger. Under the PPP program all parents-to-be, when they come into the hospital, are offered the services of a person who has a proven track record as a parent, and those who accept are assigned a lay health visitor. Those who say they don't want or need it usually agree to be studied, and these constitute the control group. The parents in the intervention group are visited by the lay health visitor before the birth of the baby and rapport is established. Material is distributed on promoting parent/infant interaction. Videotapes are shown in the hospital room of mothers and fathers interacting with infants. After the baby is born, the lay health visitor continues to have contact, both in person and by phone, and acts as a source of information if the family needs to be referred to an agency for housing, employment, education, health services, etc. The lay health visitor also serves as a model of good parenting. We have found a significant difference in rates of abuse among new parents who have that kind of program available and have accepted it as compared with control groups that don't have it.

I would like to give you an idea of how one community went about getting primary prevention programs established. Six years ago we established a Houston Chapter of the National Committee for Prevention of Child Abuse. The Greater Houston Committee for Prevention of Child Abuse came about through the concerted efforts of people in a number

of different areas of the community including, from the very outset, a lot of support from the corporate community. Prudential Life Insurance gave financial support to and helped organize initial meetings locally. People from every agency that had dealings with abusing families were invited to exchange ideas on what kind of structure should be set up.

As you know, there are numerous programs that deal with child abuse, and many of them are good. But many address the problem after the fact, and we wanted to make sure that we had the single-minded focus of primary prevention, so that left us the charge of finding out what kind of programs work. We agreed to sponsor a nationwide survey to come up with programs that met certain criteria of effectiveness. Once a year we would have a symposium to award to one of these programs a 500-dollar honorarium donated by Federated Department Stores, thereby encouraging similar programs in our community. In our first program three years ago we honored the Positive Paranatal Parenting program; the second year we honored the program called "MELD" out of Minneapolis; and the third year we honored one from San Antonio. All of them have some elements of this kind of lay health visitor, parent aid program. Our survey revealed 43 programs in the United States and Canada that met the criteria, which emphasized that the program should have some evaluation component and that it should be able to demonstrate effectiveness. In April we published a booklet called "Programs That Work: Evidence of Primary Prevention" in which we summarized and evaluated each of these programs. We are going to do a follow-up on this and there will probably be a revised edition coming out in 1988.

As a result of this program we have four agencies operating in our city that weren't there before. One has gone through 18 months of operation, and preliminary results show a significant difference between the young, single adolescent mothers who make up the intervention group and a control group who did not have the intervention of a lay health visitor.

Under the rubric of the standing committee on interpersonal violence of the UT Health Science Center, we are going to use a similar approach for other forms of violence. We plan a survey on programs that work in elder abuse and spouse abuse and hope to establish primary prevention programs in those areas as well.

Dr. Jerry Flanzer: We are finding that some of the things that work are parent education programs, especially for first-time parents, and support groups. But I think it behooves us to know why they work. In order to prevent abuse we have to have a target, we have to have some assumptions about why something works. Parent education groups work well for a number of reasons: because we are teaching some people to learn how to parent in ways they have never known before, perhaps because of the contemporary weakening of family ties, the nuclear family moving around and not having other models and so forth; but especially because people who are involved in child abuse and neglect are very lonely or isolated people who feel a lack of empowerment to make changes. Groups allow them to at least find out that they are not alone and that others are in the same boat. Sometimes I think it doesn't matter what we do, so long as people get a chance to talk to each other and learn how to verbalize their needs; some of the most powerful things that are happening in parent education groups come after the group meeting when people sit down together for a

cup of coffee. So one of my first prevention recommendations is take a look at the power of groups, self-help groups, groups that are led, all kinds of groups.

My research relating to the topic of child abuse has been in the area of alcoholism. Everything that child abuse has been shown to result from can be shown to be a factor in alcoholism as well. We can't say that one causes the other, but we do know that when a family is drinking and also abusing, the severity of the abuse is much worse than if they hadn't been drinking at all. However, almost all the studies in child abuse that can be related to normal samples will show that child abusers or their families or the generation before or after were not drinking any more than the population at large, and so it is difficult to talk about alcoholism as a cause of child abuse. I feel that in the area of prevention we certainly have to educate the alcoholism workers about child abuse and vice versa. Beyond education, we have to stop this undercurrent of a war that is going on between service providers in alcoholism and child abuse.

If we are going to talk about meaningful prevention of child abuse, we have to get to high-risk groups, but we have no organized way to find out who the high-risk groups are in our individual communities. In trying to compare our data bases and looking at means of collection from one system to another we quickly find that we don't know who we have in front of us. We need to create a data-linking system that makes some sense between organizations, that could link police data with emergency-room and hospital data and still deal with confidentiality. Another thing about a data-linking system is that it causes dialogue between people and forces people to do paperwork that they might otherwise postpone indefinitely. With such a system, we could maybe reach people in an early stage related to child abuse and neglect and target them for parent-education programs or something beyond those available through health services for pregnancy, etc. I wish each person in this room would contact our decisionmakers and persuade them that we do need a central system for data linking on a state and national level.

Dr. Eli Newberger: The pain of coming to terms with child abuse has very much inhibited what it is that we are able to perceive, measure, and act upon. Over the past eighteen months there has been an interesting correspondence released from Sigmund Freud's archives which has afforded us a realization of why it has taken so long to acknowledge the problem of child sexual victimization. The correspondence reveals that Freud at one time connected hysteria in adult women with sexual victimizing experiences that they had had in childhood. He presented his findings to the Viennese Medical Society in the 1890s but received an icy reception. When his referrals went down and he found himself in a difficult situation, he changed his theory to the view of infantile sexuality which hypothesizes that children yearn for intimate sexual contacts with their adult caregivers. He gave as a reason for this revision that adult hysteria was so widespread that if we acknowledged early abuse to be a cause, we would have to implicate a wide portion of society. Only since the mid-seventies, as a response to victims' movements, have mental-health workers acknowledged the connection between child abuse--both physical and sexual--and later symptoms of adult psychiatric disturbance. This is a important factor in the way all of us have been professionally socialized.

I would like to turn to the question of a society that is fascinated, confused, and very much stimulated by violence. An issue for future concern, research, and activism has to do with the way that violence and sexual allures are assembled, especially in the ways in which products are sold to us. [He showed some advertisements and examples of pornography that demonstrated, both the use of children to create sexual appeal and the linking of sex and violence.] I would like to suggest to anyone who is involved in investigation of child sexual abuse to ask whether pictures have been taken. Many pedophiles focus on a particular gender or age-group of children, and because children grow out of the desired phase, the pedophiles often want photos, videotapes, etc.

It is not just in the aforementioned contexts that we see sex and violence assembled and violence glorified. According to one recent study, the average American child witnesses the killing of over 13,000 persons on television between the ages of 5 and 15. [He showed a collection of cartoons that were based on violence between parents and children and between siblings and spouses.]

I feel that some of the most important issues having to do with violence have not been brought forward adequately in the public forum. I don't think you can have a conference on violence in the Southwest without a forthright addressing of handgun control. Similarly, the extraordinary impoverishment of women with children, racism, and our acceptance and encouragement of corporal punishment for children also need to be addressed. I think that it is important for those of us concerned about child-abuse prevention squarely to face the issue of the acceptance of corporal punishment and debate in public forums whether this is necessary or needs to be investigated as a cause of child abuse. Similarly, there is a relationship between child abuse and interspousal violence that needs to be probed.

One finding of the Strauss/Geler/Steinmetz survey on violence in the American home was that men who abused their spouses were more likely to have witnessed abuse of their mothers than they were to have been victimized themselves. The same study found that women who were victims of severe violence were far more likely to use violence against their children. For those of us who work in child protection, the focus is usually on the mother's capacity to protect the child. Only rarely do we ask her whether she herself is a victim of abuse. In my view we have to begin to do this in a much more systematic way, especially those of us in medical settings, who also have the opportunity to see the women's physical symptoms.

In identifying cases of abuse, we have to beware of attaching benign characterizations to those most like us while attaching more onerous labels to families that may be different from us. This is a source of the widespread illusion that the problems of child abuse and interspousal violence are much more prevalent among poor people than their distribution may actually be. I think I will end with a general cautionary note that much of what we know may be a function of what we are able to see.

Workshop

Elder Abuse

Moderator	Faye G. Abdellah, R.N., Ed.D., Sc.D., Deputy Surgeon General, U.S. Public Health Service
Panelists	Karl Pillemer, Ph.D., Research Scientist, Family Research Laboratory and Department of Sociology, University of New Hampshire
	Bert Kruger Smith, Ph.D., Special Consultant to the Hogg Foundation for Mental Health, The University of Texas at Austin
	Clairece Feagin, Legislative Assistant to Senator Gonzalo Barrientos, Austin
Recorder	Gene McGovern, R.N., P.N.P., Dallas Independent School District

Dr. Karl Pillemer: There are problems in our definitions of elder abuse. Often it has been argued that elder-abuse laws are passed as an excuse not to do more meaningful things for the elderly, such as provide decent standards of living. Are the people who are supposed to be helped really being helped? Are they being instead, as some studies have found, inappropriately institutionalized; is that the only solution? What is happening as a result of those laws?

I think we need to carefully evaluate whether the two solutions that have been most widely used, mandatory reporting of self abuse and protective services, really are the answers. We need to have more information about elder abuse. Without information, the intervention strategies into elder abuse are at best educated guesses and at worst, as in some states, opportunistic compromises between political groups.

One of the major things I think that we need to do is to have researchers, policymakers, and practitioners come together and work intensively to develop more precise definitions of the types and degrees of abuse and neglect. We could look at how the general public defines elder abuse, how professionals define it, and maybe we could develop some kind of consensus. Is self-neglect a category? What kinds of physical abuse should be included?

The second recommendation that I would make is a national study of the incidence and prevalence of elder abuse as has been done recently with other forms of family violence. Without the national incidence and prevalence figures we don't know how important the problem is or how much attention we ought to be paying to it, and we have no way to gauge the success of our interventions.

Third, I would suggest that our most reliable data will come from the elders themselves. In most of the more frequently cited studies all the data come from the

professionals who work with the abuse victims. Three or four very good studies now have involved lengthy direct interviews with victims, and these have helped us to learn the most about the problem.

My fourth point, is that it is very important that we design studies with the perpetrators of elder abuse. In past studies we have asked the elderly victims how much they punished their children, and with one or two exceptions the answer is always, "Oh, I never punished my children." This is for the elderly by far the most sensitive question that we ask on any of our surveys. Also, elderly people often don't recall things clearly. I think the perpetrators of elder abuse could give us a better sense of issues such as whether there has been a cycle of violence operating.

The fifth thing that I would argue is that we need studies that involve case-control or comparison-group designs. At the end of every year a national survey called the Health Interview Survey is administered to a sample of the U.S. population. The Health Interview Survey routinely asks about injuries received in the course of the previous year. We could include a follow-up question as to the causes of such injuries and whether they were abuse-related.

We need to systematically evaluate existing intervention programs. We know very little regarding the effectiveness of different types of intervention in elder-abuse cases.

My final point is that I believe we ought to consider evaluating existing proposed public policies for their possible impact on elder abuse. We need to consider the possibility that they will indeed cause more violence in other types of treatments of the elderly.

Dr. Bert Smith: I think we must remember that things are not always as they seem and that very often the people we blame are also victims, not of a crime, but victims. We have so many people living to much older ages, the frail elderly needing maximum services; we now have not just four generations, but five. We have the people whom I call the "papoose generation" carrying the longer-dependent young people and the very dependent old people. They are all in a sense the victims of this dependency. We see unresolved conflicts and resentments in families; the older person, who may not have gotten along with the children earlier on, now is in the house and dependent on the children. So you may have this strange mixture of old-time resentment and anger on the part of the grown child who now as caretaker of the parent has the opportunity to deprive the older person in ways that he or she felt deprived in childhood. We have young families wherein the stress of living is almost overwhelming. The young parents are trying to make a living, perhaps in inadequate jobs, raise their children, and care for the older person. In families where there has not been very much closeness, there can be other kinds of stress when the parent is dependent. The pressures and frustrations of financial arrangements and the lack of financial resources, the lack of services such as daycare, breakfast care, home-health care may be great stressors for the family. The older person may also resent his or her dependency. What happens when there gets to be too much stress? Something breaks, something gives, and very often abuse results.

Before we make the young person always the villain, we must recognize that although abused young people may abuse their parents, by the same token old people have

weapons to punish their children. This very frail little old lady sitting on this rocking chair may inspire thoughts such as, "How could I ever be angry at her?" and at the same time, "She knows where all the little places are to come at me." This is another kind of thing that causes stress and conflict.

Sometimes the children and the grandparent may not get along. Sometimes there is a bad marriage made worse by the addition of this older person. We have other kinds of psychological needs: turnabout dependence, the dependent child taking it out on the dependent parent, sibling rivalry: "You take mother." "No, I always did. You do it." All the leftover angers and resentments get to be like leftover food.

Another frequent instance of elder abuse is the self-interested caregiver. We know of cases in which the caregivers take the social security check or the SSI check, financially victimizing the older person. Yet another is the dysfunctional caregiving system, for example, the case of an abusive father whose children will not come near him. The difficult personality of the elder causes conflicts in family relationships and it is difficult to find tolerant people to provide the care.

Finally we have self-determination versus self-abuse. We may be confronted with a situation wherein an older person is living in a way that does not look suitable from our point of view. Yet what right do we really have, if this person is mentally competent, to take a person out of his surroundings?

In Austin we have a counseling service for families who are feeling stressed and who may be faced with the problem of putting an older person into a long-term care facility. It is kind of a preventive or beginning intervention area, and I think we have not done enough of this kind of thing. I think that we can do a lot simply by our profound sense of caring. One of my very favorite sayings is that any society can be judged by the way in which the powerful treat the powerless, and I think from a mental-health point of view this is what we are about in this area of elder abuse.

Clairece Feagin: Many of our communities now have emergency shelters for battered spouses and children, but we have learned that the needs of abused elders in an emergency situation are incompatible with what the existing shelters are able to offer. Shelters assume that the victims are able to provide for their own personal care: can keep their rooms, go to meals, help cook meals, dress themselves, bathe themselves, etc. In fact, it is part of the therapy that they learn to rely on themselves. However, these are not things that abused disabled persons are able to do. Essentially, they already have disability--mental or physical, perhaps both--and their condition of abuse and neglect has further restricted their ability to function.

The situation is equally dismal from the point-of-view of the caregiver. When our communities do not have support for caregivers, the caregiver must drop out of the labor force, or the elder may have to be left alone. There is such a vast array of support services that communities need to make available without cost to those that are unable to pay, and on a sliding scale for those who can afford to pay.

The local branches of the Texas Department on Aging are sponsoring a program in Texas called "Operation Bootstrap." In some areas of Texas this program is going quite

well, and in others it is embryonic to say the least. The point of this program is for each area to raise private funds for a foundation which will then generate funds, making it unnecessary to rely on tax dollars. The foundations will generate funds into the future to support elder services, to prevent abuse and neglect, to allow elders to be independent and live with dignity in their own way but with the help that their diminished capacities demand. There are several regions in Texas where area agencies on aging have been able to raise substantial funds for their foundations.

Another program that came to our attention was the carrier-alert program which can operate easily in any community. It must be set up so that the mail carriers know where the residences of elders are located, particularly elders living alone or with a problematic caregiver, for example, one who is also elderly or has a problem such as alcohol abuse. The mail carrier stands a good chance of seeing that person or observing the household daily. If mail begins to stack up, or if anything unusual comes to the attention of the carrier, he or she is encouraged to report it to the proper authorities. As older people become more impaired, their chances of becoming isolated are vastly increased; and isolation breeds depression. The mental anguish that comes from not being able to function breeds more depression. Isolated persons are at much greater risk of abuse because they are not so apt to be willing and able to fend for themselves. This carrier-alert system can go a long way toward decreasing the isolation as well as monitoring the well-being of the elderly. The greater the independence allowed a person by society, the less likely that person is to become a victim of any of the types of elder abuse that our caseworkers see day in and day out.

A new project called CEAPP, (Collaborating Elder-Abuse Prevention Project) is trying to over a two-year period, to identify service needs and service duplications; to establish short- and long-term direction of services; to identify each participant's potential area of responsibility for the prevention and remediation of abuse and neglect; to gain a commitment from all participating entities at a statewide policymaking level regarding their roles and their responsibilities; to identify any barriers to the workability of this optimum cooperative effort to prevent and treat cases of abuse; to identify areas of need in prevention and treatment for which no responsibility can be found; to develop a model public-awareness initiative which can be replicated nationwide. I am hoping that by the end of those two years we will have some ideas of what works and what doesn't work.

Workshop

Spouse Abuse

Moderator	Thomas L. Lalley, Ph.D., Deputy Chief, Center for Studies of Anti-Social and Violent Behavior, National Institute of Mental Health, Rockville
Panelists	Robert A. Geffner, Ph.D., Associate Professor of Psychology, The University of Texas at Tyler
	JanaLee L. Sponberg, M.A., Program Analyst, Military Family Resource Center, Office of the Secretary of Defense, Washington, D.C.
	Anne S. Helton, R.N., M.S., Clinical Associate, College of Nursing, Texas Woman's University, Houston
	Abbie M. Meyering, M.S., Clinical Instructor, of Psychiatry, University of Texas Health Science Center at Dallas, and Predoctoral Intern, Southwest Family Institute at Dallas
	Jeanne P. Deschner, Ph.D., Assistant Professor of Social Work, Graduate School of Social Work, The University of Texas at Arlington
Recorder	Linda Bullock, Doctoral Student, Texas Woman's University, Houston

[The panelists were asked to present information on state-of-the-art research and discussion of data available.]

Dr. Robert Geffner: The Family Violence Research Program at The University of Texas at Tyler involves a national clearing house, which means we get research studies from all over the country. In addition, we have conducted and are involved in conducting our own research in both spouse abuse and sexual abuse. I have worked as a private practitioner involved in the actual treatment of both these types of family violence. I have also been involved with treatment at crisis centers and shelters of victims of spouse abuse and sexual abuse. I got involved in the battered women's movement about eight years ago when I helped develop and was a founder of the East Texas Crisis Center and the Shelter for Battered Women in Tyler.

demographic characteristic with sociologists getting involved. The Strauss study and others around the country have looked at incidence rates and demographic characteristics of women in shelters. More recent studies are looking at personality and psychological characteristics of women who have been battered and even more recently looking at the characteristics and personality of abusers. The research on abusers is very recent, and there is still not a lot of it. The old myths about sadistic men and masochistic women do not hold, and a lot of other simple explanations seem not to be true. Current studies are looking at risk factors, and some findings seem to be recurring in repeated studies. Risk factors include coming from a family that has been abusive or violent; having low self-esteem; being pregnant; and being unemployed.

The study we have been involved in looked at the psychological characteristics of both the male batterers and the abused women. One of the things we found is that there were very few differences psychologically between the husbands who batter and the women who are being battered. Whether you look at the MMPI, the Taylor Johnson Temperament Analysis, Tennessee Self Concept Scale, Marital Satisfaction Inventory, or the Conflict Tactic Scale, the research is indicating that this population is significantly different from the norm groups. The areas that tend to show up in those significant differences for both the men and the women are low self-esteem, anger, hostility, impulsiveness, alcoholism, lack of communication, global distress, and submissiveness. In addition to looking at the characteristics, some of the research is looking at them from different disciplines. We have heard today how important the interdisciplinary approach is. We work as a team and we like to include as many other disciplines as possible.

Recent studies are looking at the effects of the criminal justice system. There is a study that has investigated reducing recidivism in abuse by arresting the abuser and actually jailing him overnight. An area Angela Brown is looking at is the relationship between homicide and past abuse. Studies are coming out on women in prison or convicted of homicide showing that many had been abused in the past by the person they killed. Another area that is being looked at now by a lot of people around the country is the relationship between alcoholism and abuse. More studies are showing that there is a significant correlation between alcohol abuse and spouse abuse. Although the high incidence of alcoholism among both men and women is not necessarily considered a causative factor, there is a relationship, which shows up on the McAndrews scale and others as well.

A new area of research that is having wide implications is the effect, both at the time and in later years, of being a child witness. Again correlations are being shown between being a child witness and perpetuating the cycle of abuse.

Another area of study is the ethnicity of the perpetrator and the victim. Research has often shown that ethnic makeup is not directly linked to abuse. What does seem to be showing up is that ethnicity is related to treatment and awareness, i.e., whether or not a case comes to the attention of police or social work agencies. Minorities are more often identified as abusers, implying that those who have higher socioeconomic status are able to avoid coming into contact with agencies.

Three other areas that seem to be coming to the forefront in recent years are 1) looking at some of the reasons why abuse relationships evolve; 2) the social psychology of aggression in general and how that is applicable to the family; and 3) sexual attitudes.

One problem that has attracted very little research is the battered woman syndrome. If a woman has been abused for a substantial length of time she gets into a learned helplessness mode, with an identifiable set of characteristics that most of us as clinicians can identify.

Part of what we do in our clearing house is to compile research from all over the country and the world concerning spouse abuse; and we have noticed an explosion of research in the past few years. Over a ten year period, beginning in the early 1970s, when research began, you get something like 400 references concerning some aspect of spouse abuse. If you look at the research done just in the past few years you get almost the same number of research references. We are now estimating somewhere in the neighborhood of 30-50 research studies being conducted monthly somewhere in this country.

The questions we need to answer are what are the causes, what can we do about it, and how do we treat it? Unfortunately, because we are such a new area of research, we have a host of methodological problems in conducting the research. Who is the sample that you are going to evaluate? What are your definitions? Do other researchers use the same definitions? What are you going to use as a control group? Are you using control groups? What do we even mean by success? What do we mean by reduction, and is reduction even good as opposed to elimination? How do we deal with the ethical issues of doing the research? These are difficult areas to deal with; people in trauma, critical ethical codes, and research ethical codes provide huge barriers to the conduct of research. Until recently there has been very little follow-up research on abused women, male batterers, or treatment programs.

There are now three new journals focusing on some aspect of violence: *The Journal of Family Violence*, *The Journal of Interpersonal Violence*, and *Violence and Victims*. We do literature reviews and have a bibliography available of some 700 articles categorized by topic area, a reference list of all of the published and unpublished research we have been able to find concerning spouse abuse. We update that quarterly with a family-violence bulletin that goes out to approximately 2,000 shelters, crisis centers, researchers, and clinicians dealing with family violence.

I hope I have given you a feeling for some of the research being done around the country and an idea of some of the directions that we need to be taking.

JanaLee L. Sponberg: I have been involved with military families for the past sixteen years in several different capacities. The face of the military has changed dramatically in the past ten years. The military force used to be made up of drafted, young, single men. We are no longer getting young single male recruits; we are getting families with children. Now we see a more educated population and a higher technical expertise, and the demands of the families have changed the way the military is dealing with all kinds of issues. We have parallels within the military to the problems that you are having in your communities across the Southwest, and we try to coordinate our efforts with those of our civilian counterparts,

to cooperate with, to coordinate with, and to communicate with them and provide a better support system for families that are suffering from violence. I can assure you that funding for our family programs is not more generous than funding for your family programs. We have to work together to make all of our services more effective and make the use of our time more effective.

The Department of Defense has responded to society's concern about child abuse. In 1974, the Law 93247 reflected a growing interest in protecting children. In 1979, the General Accounting Office came to the Department of Defense for an investigation and wrote a report that was called "Military Child Advocacy Programs: Victims of Neglect." That report along with public law provided pressure on the defense complex to provide for child protection. The Department of Defense has combined spouse-abuse programs with child-abuse programs, and we call the result *family advocacy*. We did not want to use the word *violence*. In 1981, the Department of Defense published a directive called "Family Advocacy" that dealt with our concern in trying to organize and orchestrate programs to protect families. The army, the navy, the air force, and the marine corps all have family-advocacy programs with family-advocacy representatives. These representatives may be in a medical hospital, a mental-health center, or at the family center. Army community service centers, family-support centers, and family-service centers have family-advocacy officers who are responsible for receiving reports on family violence and for providing services. The family-advocacy representative may also be the social worker, who also is responsible for drug and alcohol counseling, depending on the size of the installation. I know of one base that hired, as part of the new Family Outreach System, an outreach worker to go into the community. The presence of this mobile case worker at the base resulted in an increase in reporting of spouse abuse to nine cases in the first month of her work, up from one in the previous month. I believe that people were reporting these cases because they perceived that treatment was available.

On every installation we have a family-advocacy officer and a multidisciplinary case-management team including a social worker, law-enforcement people, investigative people, school personnel, everyone who should be there. We are able to make sure that cases are brought into a forum to make decisions on treatment for cases. We talk about definitions. Are we going to go by the legal definition of abuse or that of the military police or of the pediatrician? We are working to try to improve the delivery of services and take better care of our people. This year we revised and expanded the DOD directive and I am pleased to share that there is progress and that we are moving quickly. We have been able to use the research of the past couple of years to provide more effective treatment for our abused spouses. As you know, there is a much greater general concern for the protection of the child than for the spouse, and within this macho organization we have some people who have very definite opinions about spouse abuse. Our strategy in getting funding for spouse-abuse programs has been to use the child-abuse legislation as the primary factor and then just attach the spouse-abuse program to it. Our command education is probably one of our most positive programs. We are dealing with individuals at decisionmaking levels who fortunately have the ability to understand that the need is there for protecting people who are disempowered. Military law is what drives the military system and the uniform code of

military justice is different from the laws and regulations civilians live under. We have to work very closely through memorandums of understanding and through joint cooperative agreements to make sure that we don't have people falling through the cracks because of the federal jurisdiction.

Our organization, the Military Family Resource Center, was institutionalized two years ago. It is a DOD office, a policy and oversight branch created solely to work with the military services to coordinate efforts and improve the delivery of services. We are both a resource center and a policy office. In the resource center we maintain the only collection of research on the military family, with bibliographies and resources.

Anne Helton: The study I did on battery during pregnancy was part of my master's thesis in community health nursing. In July of 1985, I interviewed 290 healthy pregnant women receiving routine prenatal care in six public and two private clinics in Houston and asked the abused women nine focused questions. I found that women wanted to talk about the problem of battering. Fifteen percent of the women told me that they had been hit, kicked, slapped, punched, or pushed by their male partner before pregnancy and an additional 8 percent were being battered during the current pregnancy. Four percent had not been hit but had been threatened with abuse. Angela Brown's study has indicated that women who are battered during pregnancy are more likely to eventually murder their husbands; so homicide does increase with battery during pregnancy. We do know from Clairece Feagin's research that men who batter pregnant women are 3 times more violent outside the home. Of the 50 pregnant women in my study who were interviewed from private clinics the prevalence of battering was 14 percent. An additional 20 percent of that sample demonstrated behaviors that some researchers would define as suggestive of battering, indicating that maybe it was going on but that they just could not talk about it. That is how the numbers can get blown out of proportion, and you might hear that 1 out of every 2 pregnant women is battered or something like that. But of the 240 public clinic patients, 25 percent told me that they had been battered. I think that indicates not necessarily that public clinic clients are battered more but that they are more frequently researched and may be more comfortable with disclosing that information.

From my study, the battered pregnant woman is likely to be white, black, or Hispanic in fairly equal probability, 24 years old or younger (mean age, 24.6), married, on her first or second pregnancy, employed, and a high-school graduate. Of the women battered during the current pregnancy, 88 percent had a history of prior abuse. The women battered during pregnancy also reported an increase in the site of abuse, that is they were battered in multiple sites on the body, 79 percent as compared to 29 percent for the women battered before pregnancy. This tends to support other theories that when women are battered during pregnancy, the battering may be more severe. But, important for health-care providers, she is more likely to seek help for battering injuries during pregnancy. Thirty-three percent of the women battered during pregnancy talked to their health-care provider about the problem of battering versus only 5 percent of the women battered before pregnancy. Of the women battered during pregnancy, 100 percent were still residing with the abusive partner, as were 82 percent of the women battered before pregnancy.

Some of the reasons that men batter pregnant women seem to be sexual frustration, family transitional stress, prenatal child abuse, and defenselessness of the pregnant women. Prenatal child abuse may be an important factor because we do hear from some battered women that their male partner attempted to beat the fetus out of them. One is quoted as saying, "I am going to beat you until you lose the baby." Pregnant women are defenseless; it is very hard to get a divorce or get out on her own, get a job, or effect any major change in her life while she is pregnant. That may be a factor of why it is a bit more on the increase during pregnancy. Another possibility as a motivating factor is that pregnancy may interrupt the power base that a batterer has. Battering has been known to be done for reasons of power and control.

Another reason why battering seems to increase with pregnancy could be that when a women is pregnant she generally needs to seek outside help from a health practitioner, be it a certified midwife or an obstetrician. An important component of the battering cycle is isolation, so this aspect of battering is confronted as she reaches outside the family for some health care.

As a result of this study, the March of Dimes funded a program at Texas Woman's University on the prevention of battering during pregnancy, and we have developed a slide-tape show for health-care providers that has been presented to thousands of health-care providers in the Houston/Harris County area and throughout the nation. It will soon be formatted to a national program coming out of the National March of Dimes in White Plains, New York. Tom has asked that we show you this slide-tape show so that you can see what health-care providers are seeing and how involved they are getting as a result of the program.

We have seen some policy changes in Houston as a result of this research. As of September 1, the Harris County hospital district is assessing all new female patients for abuse and making sure that they have written referral in the area in case it is a problem for them. At Methodist Hospital and several other hospitals in the Texas Medical Center post, women are being assessed for abuse as part of the discharge process and given written referrals in the community. I think this shows that health-care providers want to get involved and that they are getting involved. We just need more information about the problem ourselves. I would like to show you the slide-tape show now.

The following points emerged in discussion following the presentations:

1. Geffner's risk-factor research has shown that we need to find a relationship between unemployment and battering. Obviously, not all unemployed men are batterers. Research may need to be done on their problem-solving abilities.
2. What was done for the abused women the research identified? The identified women were encouraged to talk to their physician or nurse. All women were given resources, but there was no follow-up on pregnancy outcome.
3. A study by Stark and Flitcraft has shown that spouse abuse preceded alcoholism in the family. Also it has been shown that alcoholism goes up with a man when his wife is pregnant. Nurses and physicians may be liable if they don't assess for these life-threatening situations: cases now in courts are going to test this liability.

don't assess for these life-threatening situations: cases now in courts are going to test this liability.

4. There is marked difficulty in trying to compare data because of the differences in recording. The military's model may lead us in this area. At first data between the different forces couldn't be compared because all had different intake forms. In the last two years the military has identified what information is needed, developed the forms, and is now getting significant data back. Military is hoping to share their information with all working in the area of violence.

The panelists were asked to summarize their previous presentations and give suggestions for future data collection.

JanaLee Sponberg: In the past couple of years we have looked at the dynamics of both child abuse and spouse abuse in a large sample. Let me show you some of the things in our trend analysis. In fiscal year 1985 we had reported 5,908 cases of child abuse and neglect. The rate-per-one-thousand for the Department of Defense was 3.7, compared with a national rate of 13.7. Our total reported cases of spouse abuse numbered 8,215, a rate of 7.1.

The Department of Defense denied for a long time that the military had any problems in the area of family violence, but when this was finally recognized, they moved very quickly to initiate programs to cope with it. There are five million people to deal with in the military, so we're talking about a mammoth program, which has had its problems and its successes, like any other program. We are moving from a punitive mode to a mode of treatment, approaching the problem in a multidisciplinary way. We work with law enforcement, legal, and medical personnel, social workers, recreation and school people, and each of them is also working in a multidisciplinary way, both at treatment and decisionmaking. It is especially important to share information because of our highly mobile population.

Dr. Robert Geffner: There are three areas that are constantly involved in anything any of us do. One is the research aspect: information needs to be gathered and dealt with objectively. The second is the practical: from a clinical standpoint we have to deal with a person who is probably in trauma and may have been seriously hurt physically. The third area involves policies, social and political, and the implications of the other two areas weigh on those policies. In our field we have difficulty integrating these three areas. Recent data indicate that not only are women being battered, but that violence is also going the other way. Practitioners, clinicians, and women in shelters sometimes don't want to acknowledge that, and I think that this is regrettable both from a research and a treatment standpoint.

Focusing on research with treatment, which is one of the things that I have been asked to do, I think that we need to do what works. A lot of things work, but some things work better than others in a given situation. What the research is now indicating is that shelters do certain things that are important, but that they don't do other things. Shelters are

go back to that abusive relationship. We have violence, we have lack of communication between men and women, lack of self-esteem and assertiveness, anger, hostility, and possible alcoholism. Some of the research has shown that anger management programs are effective in reducing the anger, but the long-term assessment is not convincing. We need to seriously evaluate all our treatment programs for effectiveness.

The last thing that I would like to say regarding the goals of our family violence research program, the most important of these is networking.

Abbie Meyering: We have begun the use of a family-centered systems approach in intervening in domestic violence at the Southwest Family Institute. In 1979, the average shelter patient was economically dependent. She had tried to end the violence often with the help of the police, who told her that, since they had not witnessed the assault, arrest was impossible. The implied message was that although she had been assaulted, this kind of assault was different and in a sense permitted. If she sought therapy or counseling from professionals she was often coached and warned not to provoke her husband and often the goal was to preserve the marriage. Her only legal remedy was to file for a temporary restraining order. This could be done only in conjunction with divorce, under the assumption that if she was being beaten, certainly she would want to end her relationship. But time and time again we heard that her goal was not to end the relationship, but to end the violence. So as she entered the shelter she needed protection, support, advocacy, and recognition of her health, strength, and resources, instead of the steadfast insistence that she was masochistic. She was encouraged to access and utilize limited legal and criminal remedies, and she was encouraged and assisted in finding employment.

Today, we have treatment programs for men, and we have legislation in effect which requires police to arrest if there is cause to believe there has been an assault or one is imminent. Now, when a woman enters the shelter or seeks help, it is relatively easy to obtain protective orders which allow immediate legal remedies to women who are continually physically harassed by the men they live with. This allows a woman to make a public statement of the unacceptability of violence in her home. Although police are told that they can and should arrest if they can see that an assault has occurred or is imminent, a pending class-action suit filed by the North Central Texas Legal Association has registered dozens if not hundreds of women's complaints against the police stating that they often do not arrest and do not advise a women of her legal rights and options. The precious protective order which allows women immediate protection was recently threatened when the funding that supports them ran out.

Lastly, even though the battered woman today can be believed, protected, and supported psychologically and legally, she has more trouble than ever in finding employment in the depressed economy of Texas. And if she turns to the welfare system, she will find an inadequate and impersonal system of support. We must be continually aware that each gain which has been made to provide safety and protection may be threatened at any time. We must understand that when we begin to intervene in the rigid system of the violent couple we are setting up a fertile ground for violence to recur because we are confronting the various structures and support that keep the violence going. Given

this reality, we are ever mindful of the volatility of this relationship and how important it is to know what resources are available to provide safety.

We are reporting a 91 percent rate of success, meaning that there has been only one incident of violence throughout the course of the program. As we move toward a successful use of systems theory in the explanation and treatment of spouse abuse research, we must be mindful of the many levels of systems which impact the violent relationship and take these systems into consideration.

Dr. Jeanne Deschner: I have been teaching a technique I call "time-out" to battering couples and treating battering as a relationship problem and a family problem. When a couple begins to use time-out the violence stops because they can get apart. The same kind of report is beginning to come in from other treatment programs that involve couples in their program. When they teach "time out" first, the violence usually ceases, except in cases compounded by alcohol abuse. Ft. Worth has a population of 460,000, and the police get approximately 44,000 calls per month. Two percent are domestic violence concerning partners and ex-partners, and the rest are children beating up parents, parents beating up children, or neighbors beating up each other. We picked the Polytechnic area which is a low-income, multiracial, old urban-housing area, which has the highest violent crime rate in the city, the highest domestic disturbance rate, and in fact accounts for one-fifth of all domestic violence calls--about 200 per month. We picked the evening shift, the time when most of the action occurs. There were three districts in the area; we took the one that had the largest number of domestic disturbance calls. An experimental group composed of twelve officers was trained to deal with family violence. We gave them a two-hour workshop on how to teach time-out and once a week over a period of three months went back to collect data from the police, role-play, rehearse the technique with them, and teach time-out to couples.

The other two districts in the Polytechic area served as our control group. In one of those districts the sergeant had a get-tough policy with batterers; police could arrest for probable cause and there was a specific directive out saying "Let's arrest these perpetrators of spouse abuse." The Minneapolis study shows that arresting the perpetrator is effective, and this sergeant really took it to heart. With arrest being emphasized in one of our control districts, we had a nice natural experiment.

There are basically five steps to time-out. If you want to know more about this, I refer you to my book which describes the program. First of all you need to realize that emotions are rising. Second, quickly call a time-out. We try to teach people to make a T sign like they make on television when they are watching sporting events. Third, let the other person go instead of insisting that they stay. Fourth, take time to cool off (20-30 minutes), and five, come back together and each admit a tiny mistake that he or she made, such as yell, scream, or throw things. Our experience in treatment has been that this creates a climate where the couple can resolve differences. If, instead of one insisting on being the winner and the other insisting on being the loser, each one admits to a fault, then the power of the relationship becomes more equally distributed, and they can start to resolve problems.

Nine of the 12 officers to whom we taught this technique reported that they became comfortable with routinely teaching it; however they refused to keep good data and tell us exactly how many times and in exactly which cases they taught time-out. So at last we had to rely on a data base which came from the police themselves, the radio calls which are logged in as the officer goes out on the call. These give very basic information, such as, "Boy breaking up all windows looking for his girlfriend, the same actor broke her jaw last week." With no names given it is hard to track recidivism data. Many calls come in anonymously or from neighbors. The data indicate clearly a domestic disturbance, and clearly the police responded at 21:31 hours and left at 21:58. There is a blank there where there would be an outcome number if they had made an arrest or given a ticket, so we know that they took no action in this case. After the police officers became comfortable with teaching time-out they averaged about ten minutes longer on calls, and we got an unexpected result. Arrest rates increased from 21 percent in 1985 to 28 percent in 1986 and you can see month-by-month in 1986 their citation rate for misdemeanors go up, 22 percent to 25 percent to 37 percent. In the "get-tough" control area the arrests got up to 24 percent in March and then sank to 17 percent and then 13 percent. The officers were reluctant to arrest batterers and found a way to get around their sergeant's directive.

During the time of this study, the Ft. Worth, Texas, homicide rate became the highest in the nation. At the same time that all homicides were going up, the percentage of homicides as a result of domestic disturbances went down from 44 percent to 25 percent.

The following points emerged in discussion following the presentations.

Q: 1) How are we defining success in treatment? 2) Is this a Hawthorne Effect? and 3) Is data from random samples?

A: (Geffner): Researchers' definition: decrease in violence; practitioners' definition: not reduction, but elimination. Follow-up data are crucial to research, define amount of time. (Meyering): Long-term follow-up on their 23 couples is very important. (Deschner): Couples that go through the program still have problems, they have just ended the violence. Audience member expressed concern that emphasis on working with couples would result in less protection for women. Also that when violence is stopped, men become abusive in other ways, such as economically intimidating, etc.

Q: Did the citations rate go up because the time-out failed?

A: (Deschner): May be true. Officer might have taught time-out, failed, and then realized this couple needed an imposed time out.

Q: Does a restraining order apply only man to wife or any other family, i.e., lesbians?

A: (Meyering): Yes, it applies to any relationship.

Q: Do you know whether during times of war we have more violence in family than when not in war?

A: (Sponberg): Don't know if this has been investigated. The Marine Corps has looked at its drill sergeants, identified a problem, and referred couples having a problem into a group. Also have a training office to defuse the stress.

Q: What is being done in emergency rooms?

A: (Dallas Women's Center for Parkland Hospital): Sixteen volunteers on Thursday and Friday night talk with women who are victims of family violence and give resources. (Harvard Model): If a physician has reason to suspect spouse abuse, the social worker must be called. Charts are reviewed daily to make sure this is done. Nurses may be the most important. If woman does not say "battered", the nurse can write the words and what she sees and take photos if possible.

Q: (Abiliene Police Department): It is hard to change a fundamental police response that has been taught for years. What is it that you want us to do? Today I heard about time-out, which I feel comfortable with. So what do you think is the appropriate response? Are police being used as scapegoat?

A: (Deschner): I'm tremendously impressed with the Fort Worth police. I'm advocating that the police take a referee response. (Meyering): I'm for spouse abuse being treated as a crime, therefore arrest. But I realize the frustration that the police have. (Geffner): There is a short-term and long-term solution. When called, the short-term solution is to arrest because a crime has been committed. The long-term solution is referring the family to a program like what we've been talking about. (Lalley): Who can recite the Texas Domestic Law? If you respond to a call and have probable cause to believe assault has occurred or will occur, you may make the arrest. If there is further violence and you have not made the arrest, you are held liable. Police must also provide written referrals.

Q: How many favor strict enforcement of the mandatory arrest law?

A: (Geffner): You need to take the responsibility away from the wife because many times she doesn't want to press charges. (audience): The importance of mandatory arrest is that it helps the community recognize this is a crime. (Meyering): It is a good leverage to get the people into the treatment they need. (Lalley): In Connecticut, the judge gives the batterer a choice; he can pay $500 or go into treatment. In a two-month period, everyone has paid the $500. (audience): The arrest policy in New Mexico is similar to that of Texas; all arrested go to family counseling, then go back to sentencing, and are given a choice of more counseling or jail.

Q: My impression has been that most shelters are filled. Are there enough shelters? Is the government going to take responsibility?

A: (Meyering): Yes, this is real. The shelters are full and police are going to find them full and maybe this will wake up the community.

PART III

- ◊ Issues Related to Victims of Violence
- ◊ Victims of Violence

Symposium

Issues Related to Victims of Violence

Moderator	Richard H. Collins, B.A., President, Associated Texans Against Crime
Panelists	Robert S. Pynoos, M.D., M.P.H., Associate Professor of Psychiatry, Neuropsychiatric Institute and Hospital, University of California at Los Angeles
	Michael R. Mantell, Ph.D., Chief Psychologist, San Diego Police Department
	desAnges C. Eckert, M.P.A., Central Region Program Manager, Oklahoma Department of Mental Health, Oklahoma City
	Patsy Day, Founder, Victims Outreach Program, Dallas
	Roy B. Allen, Ph.D., Research Analyst, Southwest Center for the Study of Hospital and Health Care Systems, Houston
Recorder	Kenneth A. Zimmern, M.A., Dallas

Dr. Robert Pynoos: While it may be recognized that children who are direct victims of violence frequently exhibit posttraumatic stress symptoms and other symptomatic reactions, it is less well known that children who witness violence or have friends involved in violent acts may have similar responses.

At the UCLA Neuropsychiatric Institute and Hospital, we have established a research and clinical prevention intervention program in the areas of violence, trauma, and sudden bereavement in childhood. We are also following several populations of children exposed to different types of violence including child witnesses to spouse abuse, homicide, rape, suicidal behavior, and hit-and run incidents and child victims of juvenile gang violence and community violence. During our initial clinicial descriptive work, we developed a standard semistructured interview format for children exposed to violent events. More recently, we have adapted a posttraumatic stress reaction index for use with children, developed a child inventory of grief reactions, and designed an interview questionnaire to assess the child's postviolence responses based on parent reports.

The posttraumatic stress disorder experienced by children in response to violent incidents is similar to the adult disorder in the following four central features: the severity of response is related to the extent of exposure to life threat or the witnessing of injury or

death; children exhibit and report the whole range of symptoms described as Post Traumatic Stress Disorder (PTSD) in DSM III; the symptoms of reexperiencing and changes in emotional responsiveness most differentiate those children with severe posttraumatic responses from those with mild responses; and states of increased arousal are prominent (Pynoos and Nader, in press).

Although children rarely report adult-like flashbacks, they reenact parts or all of the incident in their play. Children describe posttraumatic dreams and fantasies that depict the violence or some form of violence or life threat and sometimes include acts of revenge against the assailant. They report reduced interest in usually enjoyable activities, feeling more distant from their friends or more alone with their feelings, and desiring not to be aware of their own feelings. Parents are not always aware of this sense of aloneness and isolation because the child may continue to cling to or seek comfort from others.

After a violent event children report or exhibit a variety of new symptoms and behaviors classified as increased states of arousal, including startle reactions, sleep disturbances, and hypervigilant behavior. Two types of new fears may occur. Children may become afraid of specific locations, concrete items, and human behaviors that specifically remind them of the incident. They may also exhibit more generalized fear at moments of feeling vulnerable, for instance, when going to bed. Difficultly concentrating or remembering what is learned is associated with sleep disturbance and intrusive phenomena.

Avoidance behaviors and recurrent anxiety in response to traumatic reminders is prominent in children as well as adults. For example, we have observed that in the acute aftermath of a violent event (e.g., a sniper attack) some children become transfixed by violence on TV and experience renewed anxiety and rage, while others avoid any TV reminders and will suddenly leave the room when they occur. Feelings of guilt are reported; children exposed to violence have expressed immediate or delayed guilt over being unable to provide aid, being safe when others were harmed, or believing their actions endangered others.

Violent incidents often lead to death, and our work has provided evidence that there is both an independence and an interplay between grief reactions and posttraumatic stress reactions in children. Comparisons of the course of childhood grief with adult grief have revealed a commonality between the two. Like the grieving adults described by Parkes (1971), we found children often attempt to disbelieve reality and search for the lost person, attempt reunions in dreams and fantasies, experience anger, pangs of emotional pain and tearfulness, sadness and depression, separation anxiety, and restlessness.

School-age children appear to be confused, frightened, and disturbed by their normal grief reactions. They may interpret illusionary experiences and reunion fantasies of the deceased as indicating the return of the dead or the appearance of a ghost. Children are less likely than adults to share their grief experiences with others, and their lack of a sustained manifestation of sadness may lead adults to be unappreciative of the nature and intensity of the children's grief reactions.

Worry about the safety of a significant other during violent incidents is a source of extreme stress for children. Children may become anxious in the absence of the other

person and may remain apprehensive about the person's whereabouts or safety. These symptoms can disturb sleep and normal daily functioning. Irritability with, or even rejection of, another person may reflect the child's continued sense of insecurity about that relationship.

One of the immediate consequences of a violent occurrence is its power to serve as a reminder of previous experiences. In response to a current traumatic event, children have become preoccupied with a prior family suicide, severe accidental burn, death of a sibling by drowning, and other previous incidents of violence, sudden bereavement, or injury. As a result, there may be a recurrence of symptoms including intrusive images, disturbing effects, renewed fears, and disrupted sleep.

Exposure to violent incidents can have a significant influence on immediate and subsequent developmental processess. It can cause deleterious effects on cognition, including memory, school performance and learning. Children may develop significant alterations in their personalities such as reduced impulse control or increased inhibition, an attraction to danger, or a debilitating sense of fear. They may radically change their views about the safety and security of human relationships and about their own futures. The persistence of increased states of arousal, for example sleep disturbances, may have a chronic affect on other areas of a child's life. Further studies are necessary to investigate the more constructive influences on child development, for instance, improvements in school performance or more empathic responses to others.

Differences in age and developmental phase are significant in determining how the child is able to assimilate an event. In addition, each age group is vulnerable to certain behavioral changes. Preschool children are most likely to exhibit decreased verbalization and cognitive confusion, an increase in anxious attachment behavior, and other regressive symptomatology. School age children are more apt to react to violence with aggressive or inhibited behavior and with psychosomatic complaints. Their behavior may be both more inconsistent and more reckless.

In the immediate aftermath of violence, triage of children includes assessment of incident-specific factors that are known to be associated with a severe reaction, including the child's degree of exposure to the violence and/or the viewing of injury or death as well as the personal impact of the injury or loss of another. The child can be assisted through individual, family, classroom, group, and community interventions. Individual treatment provides the path to restoring the personal integrity of the child. To do so it is necessary at the earliest possible occasion to thoroughly explore the child's subjective experience, to help the child to understand the meaning of his responses, and to integrate the experience into the continuity of the child's life.

The use of a specialized interview approach is of critical clinical importance. The goal of the therapeutic consultation is to identify the immediate effects of the trauma, with the child's attention and energy reserved exclusively for this task. The child is assisted to identify traumatic reminders that elicit psychophysiological reactions, intrusive imagery, and intense affective response. The result is an increase in the child's sense of being able to anticipate or at least manage their recurrence.

The family is the key to addressing the feeling of vulnerability and to restoring a sense of security. The initial parent interview can be used to educate parents about understandable and expectable child reactions. We are designing programs to facilitate parenting functions in the aftermath of a violent incident or sudden bereavement, especially for parents or guardians who themselves have been seriously affected.

Intervention at the community level may take many forms. Emotional assistance for the child witness can begin even in the emergency room when family members have been brought for emergency services. Injured children, themselves, may require special supports during their hospitization to help them through any recurrences of traumatic anxiety. The reintegration of traumatized or bereaved children into the classroom can be a critical step in the recovery process. A coordinated plan between the mental health professional, teacher, and family can help to minimize the traumatic impact on school conduct and performance. The grief process is prolonged, especially after a traumatic death. Group work with children after a loss is a promising modality of treatment, especially in the school setting. Finally, attention must be paid to the interaction of trauma recovery and participation in criminal proceedings. Liaison with judicial agencies is important to ensure that procedures do not compromise the child's recovery or the judicial process.

Dr. Michael Mantell: Human induced violence leaves its mark not only on the body, but on the spirit. The psychological aftereffect of a major traumatic event is like a malignancy stealthily creeping within an individual. The posttraumatic stress associated with violence influences many beyond the immediate circle of victims. Rescue workers have been ignored by health professionals despite significant mental and physical complaints following crisis situations.

Since 1980, I have been the Chief Psychologist for the San Diego Police Department. My involvement with rescue workers and police officers grew from work I did with the police in the aftermath of the mid-air collision of a Boeing 727 and a Cessna 172 in September 1978. The officers who responded immediately to this particular tragedy had no recourse to organized, systematic programs of psychological services. Some sought help from the community mental health professionals, but close to a dozen police officers applied for and won stress disability retirements following the accident.

This was not the case, however, after the San Diego, California, McDonald's massacre in 1984. In 1980 the city had established a program of confidential psychological services for city employees. The National Institute of Mental Health also provided a contract to study the impact of the event on police officers. Because of the immediate recognition of and response to their trauma, no officers were lost to stress disability retirement.

Based on the successful efforts of the Psychological Services Team in the McDonald's situation, I was called by NOVA to head a team of mental health professionals from around the nation to deal with the aftershock in Edmond, Oklahoma, after that community suffered a massacre on August 10, 1986. This time fourteen people were murdered in a post office.

The goals of crisis response teams are to help victims deal with the symptoms they experience, to minimize the emotional pain they feel, to prevent the "secondary injury" they may be subject to, and to help restore a sense of power and control. Stabilization is the key focus, with safety and security, ventilation and validation, and prediction and preparation the major components.

When I arrived in Edmond, the coordinating efforts of the Oklahoma Department of Mental Health Regional Program Manager, and her Public Information Officer; the Oklahoma Department of Public Safety's Director of Psychological Services; the Director of the local mental health facility, North Care Center; and NOVA had been established. This Crisis Response Team met for the first time at the Oklahoma airport.

We established three basic target groups for service: the 90 employees who survived the attack, their families, and the families of those murdered. The next target group was the public safety personnel who responded to the massacre--police, emergency medical technicians, coroners, hospital staff, highway patrol, FBI, and postal management. The final group consisted of the Edmond community in general.

The local coordinating team arranged meetings between the target groups and the response team. Team members were dispatched individually and in groups to those meetings. Over the next 48 hours, we listened to those with whom we met and reinforced their efforts to address the pain, shock, disbelief, denial, anger, fear, and helplessness experienced to varying degrees by a community of 50,000.

In the meetings and training sessions, team members highlighted the unique stress of human brutality, mayhem, and murder. The kinds of responses and emotional reactions the victims and community are likely to experience, both immediately and in the long term, were reviewed. Local care-givers were instructed in crisis reaction and crisis intervention for victims of crime as well as appropriate psychotherapy treatment.

Within 48 hours of the shootings, 3 of the team members participated in a 90 minute debriefing for the postal employees. Besides arranging the team's meetings, the local coordinators also prepared press packets, arranged a press conference, and organized individual interviews.

What was learned? First and foremost, it is clear that a team approach is critical. There is no room for ego, power, control, or ownership issues. There is also no time for a team to get to know one another. Knowledge, background, style, and strengths must be part of the baggage each member brings to the crisis.

The team must have a clear leader who can comfortably delegate responsibility while maintaining an overall understanding of the major goal--stabilization of victims and guidance for local experts and care-givers. Local coordination, however, is essential. The day-to-day mundane needs of the team need to be coordinated by someone from the area.

The efforts of the Edmond Crisis Response Team were successful in providing consultation, education, guidance, and support. Direct service had little or no place in Edmond. However, it could be necessary in other circumstances, so the team needs to be flexible in its approach. As in any good consultation process, reading the system, and fitting in easily in a nonoffensive way is critical.

desAnges Eckert: The event that Dr. Mantell described has been named the third worst mass murder in the history of the United States. It happened at 7:00 a.m. on Wednesday, August 20th, where there were 90 people in a very small building. Fifteen were killed, and twenty were injured. Our patients included both wounded and families of deceased victims. Edmond, Oklahoma, is a community of 50,000 people which is part of Oklahoma City. It is a very religious community with many strong ministers. This event followed on the heels of three other incidents which were traumatic for the community: a rape/murder, a shooting of two clerks at a grocery store, and a tornado which had leveled one of the residential areas of Edmond. The mayor was out of town when the massacre occured. The postmaster, who had only been six months in that position, was also out of town when it occured. The Community Mental Health Center, which was involved in responding, is the smallest facility of its type in Oklahoma, with a budget of just barely over $500,000. Although he was eager to help, the executive director of that mental health center had been there only about two months. Nevertheless, there was a tendency on the part of the members of that community to believe that they could handle this massacre themselves. A tornado-response team had formed in the previous disaster, with the ministerial lines forming a very strong response to the tornado victims.

Most of the literature deals with the clinical aspects of treating victims of crime, but it doesn't deal with how we can organize ourselves. How do we go about identifying the leadership in the community and respond? How do we go about relating to that leadership in the community without being intimidating or threatening? We were being asked for advice that we did not know how to give. People wanted advice about a memorial. The mayor wanted to know about the politics of responding. The city council wanted to know what they should tell their constituencies.

There are five things that the surviving victims of the Edmond massacre are still dealing with. The first issue for the mental-health clinic is how to bridge between processing and responding to the posttraumatic stress symptoms that the postal employees are exhibiting. Second, how to bridge from that point to actual clinical testing and long-term treatment, because some of these people were at high risk before this occurred. Third, a struggle has developed between the management and the union of the emergency-care workers. Fourth, job performance has become an issue for the post office. Vehicular accidents are occurring, a problem they never had before at this post office. Mail sits for days on end without being delivered. Last, the mental-health clinic is dealing with how to study and learn from this event and still continue to provide its normal services.

I would like to suggest that, along with the regional team concept, there needs to be some mobilization in the local community as well. Networking is something that community-based service agencies are less able to do and less interested in doing now in a period of declining funding. I would appreciate it if any of you can make any suggestions for us from the future.

Patsy Day: I am not an expert; I am a victim. On June 23, 1985, my fourteen-year-old daughter Jennifer was abducted from her new job at the Donut Shop a block from our house and murdered. We found her body in Plano four days later. No money was missing

from the cash register. We have no idea who did it or why. All of the traumatic symptoms that have been described to you today by these eminent experts, I've lived through. The nightmares: I have to tell you that hearing them clinically described in no way compares with living with them for 16 months.

There are some things I would like to bring to your attention about being a victim that these people have not mentioned. The first problem that victims face is what we call the "blaming the victim syndrome." I have heard, even at this conference, that there are "deserving victims". One of the first things that happens after a murder, particularly a spectacular murder or a rape, is that everyone tries to find some way to blame the victim. It may occur in the newspapers or it may occur in the questions asked of the victim after the crime: "Why were you out alone?" "What were you doing out at that time of night?" "Didn't you know that you shouldn't be going out with that man?" I had one woman tell me that "you just can't go anywhere alone anymore."

Another thing, from listening to the speakers here today and their descriptions of the postal workers' fatigue, their diminished work performance, and their mental disorientation, I can assure you they are going to suffer for several months. When I went back to work, even six months after Jennifer was murdered, I could not remember details on the job, like whether or not my boss was in the office. It's as if your head is stuffed with cotton and nothing else can penetrate. It's been sixteen months since Jennifer's murder and I'm just now, within the last three weeks, feeling my appetite come back. Just now, I'm able to get enough sleep. You wake up at 4:00 in the morning and the brain starts twirling and you can't go back to sleep.

According to Parents of Murdered Children, it takes a minimum of 18 to 24 months to stabilize after the violent death of a significant other. The different stages of grief that you go through can be catalogued but you can't always say how long a stage is going to last because any little thing will throw you back into a previous stage. I did not witness my daughter's murder. I never saw Jennifer's body. But I got out of the car the other morning to get a doughnut and I turned around and found myself nose-to-nose with a quote "street person," grubby, wanting a handout. In the past, I might have given him the handout and gone on my way, but this time I shook for 45 minutes afterwards.

Another very difficult thing for victims is not being given permission to feel what they feel. They are told, "Well, don't worry." The best thing that happened to me the day Jennifer disappeared was when a friend of mine walked in and I said, "I am terrified" and she said, "Of course you are." She was the first person in six hours who had given me permission to be terrified. Not only was I terrified, I was feeling guilty because I was terrified. Victims have a lowered self-esteem as a result of having someone in their family killed or victimized. I can't get on with my life because I have not had the time yet to deal with the emotions and the trauma.

When I began the stage of grief I started looking in Dallas for some organization or some people who had been through the same type of experience, to find out if in fact I was going crazy or my response was normal. I had no one whom I could bounce my feelings off, no one to compare myself with. I called the police department social services. They referred me to Parents of Murdered Children, who were not then meeting. Now, with the

encouragement of the Police Department, we have formed a group in Dallas called "Victims Outreach" to help victims and their families heal. Victims Outreach informs victims of their rights and their responsibilities and gives them a place to voice their emotional trauma. We have a victim's assistance program in Texas that is offered through the District Attorney's Office. When the perpetrator of a crime escapes detection or is a juvenile and therefore not prosecuted through the District Attorney's Office, victims are often unaware of the assistance program. So until very recently, the D.A.'s Office had no idea that there were victims who were not getting crime victims' compensation packets. We can be contacted by addressing letters to P.O. Box 515727, Dallas, Texas 75251. We support and assist victims through the investigation and the trial process. We accompany victims to trial and help to prepare them for the experience, which can be especially traumatic because the legal system is so insensitive to the needs of victims. We work with the police, the prosecutors, and the judges to try to help them become more sensitive to these needs. The Dallas Police Department has been wonderful. We are going to collaborate with them in some training films to help their officers become more sensitive to victims.

We assist the media in understanding the effects of news coverage on crime. We also want to educate the general public about crime, the criminal justice system, and the effects of both on the victims. The criminal justice system revictimizes the crime victim. For instance, families of murder victims are frequently subpoenaed by a defense attorney and never called to testify, because the lawyer doesn't want the family of the murder victim in the courtroom, to influence the jury's feelings. If they are subpoenaed, they have to be separated from the rest of the witnesses, so they are not allowed in the courtroom.

We want to promote equal rights for victims under the law. We offer monthly support meetings. We do telephone support with victims themselves trained as counselors. We have a lending library on grief and overcoming victimization. We offer contact with other state and national victims' groups to the people that are in our group.

We didn't have any choice about what happened to us. It was visited upon us; our only choice is in our response to it. Victims Outreach offers us a way to deal constructively with our emotions and a way to help other victims who are going through this same thing.

Dr. Roy Allen: The impact of emergency medicine on victims of violent crime emerged in 1958 with Marvin Wolfgang's major study of homicide and it was reported in a book titled *Patterns of Criminal Homicide*. In 1964, Pittman and Handy published a work which was an examination of the patterns of aggravated assault. They found that the temporal, spatial, demographic, and interactional patterns for aggravated assault were for the most part identical to those patterns for homicide. Another researcher, Hugh Barlow examined the response times of ambulances to victims of serious assault, expecting to find a linear relationship, in that the more time spent transporting and so forth, the more likely that the victim would die. However, the relationship did not prove to be that simple.

For the current study that I am going to report on, I've collected data from the emergency medical trauma service (EMTS) department. The basic unit of analysis is the individual violent crime victim, injured severely enough to require treatment at Ben Taub Hospital's level one trauma center, as well as requiring the performance of one or more

inpatient surgical procedures. The time frame is January 1st through May 15th, 1982. The Ben Taub trauma center during that year averaged 350 patients a day. In 1982, the trauma center treated 2,042 gunshot victims, 1,477 victims of stab wounds, and 2,353 blunt assault victims. Our data came from three sources: the Ben Taub Trauma Center and Department of Surgery, the Houston Emergency Medical and Trauma Services Department, and the Houston Police Department. EMTS data included the time of dispatch, arrival at the scene, departure from the scene, arrival at the hospital, the types of patient-care procedures administered, patient medical assessments made by EMTS on the scene, and whether or not the police were at the scene. Houston police reports included spatial and temporal characteristics of the offense, victim and offender characteristics, and weapon characteristics. The injury data from Ben Taub served to score the injury severity using the Abbreviated Injury Scale.

[Dr. Allen quoted statistics derived from his study which may be found in his paper, "The Emergency Medical Response to Violent Crime Victims," included in appendix C of this volume.]

Five variables appeared to correlate with the injury-severity score. Mortality correlated highly; obviously, the more severe the injury, the greater the likelihood of lethal outcome. The type of weapon used correlated well with injury-severity score, a firearm, obviously, being a more lethal instrument than a blunt instrument. The number of EMTS patient-care procedures administered on the scene showed a small correlation. There was a small but significant negative correlation between age and injury severity, indicating at least to some extent that the younger the victim, the more extensive or severe the injuries. The explanation for this phenomenon has to do perhaps with life style and risk-taking behavior. And finally, the presence of witnesses and third parties was positively correlated. Barlow in his 1983 study suggested that the presence of witnesses may serve to expedite the call for assistance, however, Luckenbill and Felson found that witnesses or third parties were likely to be supportive of the offender and/or the violent act. I think perhaps the findings of Luckenbill and Felson are somewhat supported here. Part of the reason why there are more third parties present in homicide cases may be that the police investigate homicide much more thoroughly. No correlation was found between the number of external wounds inflicted and the number of witnesses or third parties. I examined the relationship between mortality and the number of EMTS procedures performed, EMTS time at the scene, the transport time, the total EMTS service time and the age of the victim. None of the correlations was statistically significant.

In conclusion, obviously there is much more involved in the emergency medical response to victims of violent crime than a "scoop and run." Response time to the scene was rapid with very little variation, although a great deal of variation exists in the amount of time spent at the scene. This may be accounted for by the number of procedures performed by EMTS people. Overall response time and transport time were relatively quick, averaging approximately 30 minutes. Several variables were related to injury severity. These include the number of procedures performed, the victim's age, victim mortality, weapon, and the

presence of third parties. Outside of this injury severity, no factors were found to be statistically or signifcantly related to mortality.

Conclusion of this Symposium

The panel called for a national task force, which in the event of a crisis would be dispatched to empower and/or support the local agencies already in place. This task force would facilitate the coordination of rescue workers, health professionals, mental-health professionals, the press, and community leaders, thereby minimizing the devastation and ramifications of violence on its victims.

Luncheon Address

Victims of Violence

Introduction	Kern Wildenthal, M.D., President, University of Texas Health Sciences Center at Dallas
Address	Lois Haight Herrington, J.D., Former Assistant Attorney General of the United States

The Honorable Lois Haight Herrington: We have a relationship here today; it's your duty to listen and my duty to speak and hopefully we're going to finish about the same time. I've been involved for four and a half years in the Department of Justice. I think that's pretty heroic. I'm leaving the federal government, but I am not leaving the victims' movement and the movement for victims of family violence and crime prevention.

When I first heard that there were 40 million victims of crime in 1980, I was going around telling people, "There are 40 million victims of crime." They were responding, "Oh yes. Oh well, what are we going to have for dessert?". Almost 6 million of these are victims of violent crime and still the attitude seems to be much the same. Around the United States I tell people that there were almost 6 million victims of violent crime in the United States last year. And the response is, "Well you have to expect to be a victim." We can never, ever expect to be a victim of crime. We should demand protection from our government whose duty it is to protect us. We should demand protection from our law enforcement, from our prosecutors, from our judiciary. We should demand from these same people sanctions for the wrongdoer commensurate with the harm done. As long as we tolerate violence, we will have it to tolerate.

I'm going to talk to you today about the approximately 6 million victims of violent crime, and some of the things they face in our system today. Approximately half a million of these are victims of armed robbery. Last year in the United States we had approximately 18,000 victims of murder; approximately 20 percent of those were victims of family-related murder. We had almost 150,000 forcible rapes in the United States. Let us focus on the human impact.

I had the privilege of being a delegate to two conferences: one in Nairobi, Kenya, the Conference for Women on the Status of Women and the other one in Milan, Italy, Crime and Crime Prevention. We are not the most violent country in the world, but we do keep the very best statistics and we report in the most honest way we can about what is going on in our country. One of the things I kept hearing when I was in Milan at the Crime Prevention Conference was what a draconian country we were. I said, "What do you mean, draconian?" They said our sentences are terrible. I said, "Sentences...for what?" The average time served for rape is approximately four years. The median time served for armed robbery is two-and-one-fourth years. The median time served for drug offenses, our

big war on drugs, is approximately 14 months. There are a lot of myths about the United States and I think we have to dispel some of them.

We are not the most violent country in the world. We are the fairest; we have the most fair (which we should be so proud of) criminal justice system in the world. Except to the victim. We protect criminals because we don't want to convict one innocent person. We make sure their rights are protected, that Constitutional guarantees are there and in place. But how do we treat our victim of violent crime in the United States? How do we treat approximately 6 million people when they do report a crime? Four years ago, I chaired the President's Task Force on Victims of Crime. We held hearings throughout the United States to find out how the victims of crime were being treated. We found out most of them were being treated terribly. One woman who was robbed at gun-point, kidnapped, and raped said "that [being a victim] was a terrible, terrible experience, but my disillusionment with the criminal-justice system was far more painful because there I had expected justice and I received none." Over 50 percent of violent crimes are not reported, and the victims told us that they were not going to report crime because victims are mistreated; because they are ignored; and, most insidious of all, because they are blamed. "What were you doing out on that street at nine o'clock at night, Mrs. Jones?" As if you don't have a right to be on the street. We can do something about really protecting our victims and making them feel safe about coming forward to testify and cooperate with the system. Don't forget, the victim of violent crime knows what the criminal is capable of. Their fear is quite warranted, and we should give real attention to that fear.

The system is not responsive to the victim in two basic areas. One is continuances. We found cases continued time and time again. Nobody bothered to find out if that was convenient for the victim or if the victim wanted this. Before I was a prosecutor, I had a very short term as a defense counsel. I learned one thing: age that case! Get that case so old that the victim will die, get sick, get fed up, move away, in some way not cooperate. We can do something about outrageous continuance. We can insure the defendant's right to a speedy trial. Let's get that case over with so the victim can get on with his or her life, because many victims' lives are on hold until they can put the experience behind them and move forward.

The second area in which the system is unresponsive to the victim is sentencing. We found out that most sentences are pronounced without the judge's ever knowing what has really happened to the victim. The sentence must be commensurate with the extent of the harm done and with the degree of intent to harm. What's the effect of the crime on the victim and the victim's family? That is a victim impact statement. We're asking that the victim be allowed to come in and say "Your Honor before you pass sentence, please let me tell you about the threats I've received...Let me tell you about the mail that I've received from the defendant...about the injuries...about the cost...about the consequences of the crime." That is justice, when we raise a scale and balance these interests.

Another area which needs to be dealt with is the burden that the crime has imposed on the victim. Nowhere is that better illustrated than in the case of Betty Jane Spencer, a woman who was in her Indiana farmhouse with her sons when four hoodlums on a crime spree broke in. They executed all four of her sons. When she met the president two years

ago she said, "I am the innocent victim of crime and I'm also the taxpayer. Now I am paying for these people while they are in prison. I had over $22,000 in medical fees and burial fees for my sons, and yet I have received not one cent." She is the innocent victim. She desperately needs psychiatric help, she desperately needed financial help. That is an example of the burden imposed by crime, and I think we have to learn how better to handle people who have been violently victimized and do not know how to cope.

The final area I'd like to address is crime prevention. Crime prevention does work. Three years ago I was in England at a conference and I talked to the second in charge of Scotland yard. He said, "Mrs. Herrington, we do not believe in crime prevention in England. We think it's displacement." I said, "Well, you live on an island: why don't you just displace it off your island." Of course, I was not very popular. Three months ago, the attorney general of England came to my office and said, "Would you please tell us about your crime prevention? It seems to be working". I said, "You bet. We'll be happy to share anything we have." Crime prevention not only reduces our burglary rates, and the violent crime rate in the neighborhood; it forms a cohesive network of ties with our community. We're starting to care about each other. When you have a community that pulls together and watches out for each other, prevention works. We have done a lot in the United States for victims. Approximately four years ago only four states had victims' services legislation; now approximately 31 states do.

I want to leave you with one startling statistic that tells how much more we have to hold the offender responsible and not blame the victim. For every one hundred violent crimes in this nation, forty seven are reported to the police. Twenty-two assailants are arrested. Sixteen cases are filed for prosecution. Eleven cases result in conviction. Only two of these go to prison. Our prisons are overcrowded. Over the past twenty years, while prison capacity was rising 27 percent, serious crime rose 332 percent.

We have some priorities to fix and we have to start making some really tough choices with our dollars. Thank you for caring about criminal-justice perspective.

PART IV

- ◊ Assault and Homicide
- ◊ Rape and Sexual Assault
- ◊ Homicide and Assaultive Violence

Workshop

Assault and Homicide

Moderator	Judge Edward Kinkeade, 64th District Court, Dallas
Panelists	Deborah Prothrow-Stith, M.D., Assistant Professor of Medicine, Boston University
	Lee P. Brown, Ph.D., Chief of Police, Houston Police Department
	Paul Blackman, Ph.D., Research Coordinator and Deputy Director, Information and Members Services, Institute for Legislative Action, National Rifle Association

[Panelists were asked to discuss state-of-the-art research and available data.]

Dr. Deborah Prothrow-Stith: The usual homicide setting is among people who know each other, who are drinking, arguing, and who have a handgun. Studies that have been done include post-mortem blood samples of homicide victims and history recall of offenders. Both types of studies suggest that half of the victims and half of the offenders had been drinking at the time of the homicide. What some of us feel may be a racial issue may more likely be part of a socioeconomic issue. Because blacks are overrepresented among the poor, they're overrepresented among the homicide victims. Unfortunately the available assault data is incomplete. What data we have is fairly regional and local, and there is no national source other than law enforcement.

One of the best sources of assault data is the Northeast Ohio Trauma Study by Dr. Baronsit, published in the *American Journal of Public Health*, July 1983. This study calculated the cause-specific trauma in an area population of 2.2 million, the standard metropolitan statistical area (SMSA) that included Cleveland, Ohio. The data were collected from 97 percent of the emergency rooms in the SMSA for the year 1977. The assault rate was calculated at 862 per 100,000. In that time period and that SMSA, the emergency rooms reported four times the numbers of assaults that were reported to the police. This would suggest that we need other than law enforcement agents as data collection sources. The FBI does collect data in the uniform crime reports on assault and other categories, as it does homicide, but not the characteristic data. Emergency-room data are underreports, and there is no standard diagnosis for trauma in the emergency room. Some may get coded as intentional injury and others may get coded as a broken arm.

Many of us who are designing programs to prevent interpersonal violence assume that the assaults have similar characteristics to the homicides in that they are "acquaintance" by nature. A survey of 196 students in a Boston high school over the course of three years does reflect the acquaintance nature of assaults. But we don't know the attitudes of parents

and of the community on how much fighting is too much and when, if ever, fighting is condoned. I do think overall social attitudes have something to do with the fighting behavior of kids and the assaultive behavior that the police and the emergency room personnel see. In the classroom, when I talk about movies such as a recent one in which the hero's daughter is kidnapped and he uses several tanks and a battery of automatic weapons to kill a million people to get her back, the students say, "What would you do if I kidnapped your daughter?" I think we underestimate the impact of the message that if you have a noble cause, the extreme to which you can go in terms of violence is unlimited.

I also think that homicide rates reported by the Center for Disease Control are a reflection of completed assaults. If we are to define the problem so as to design appropriate prevention strategies and if we are to use our data to evaluate and monitor these program strategies, then we need to dramatically improve our data collection resources, particularly in the area of nonfatal assault.

Dr. Lee Brown: Let me begin by expressing my appreciation for this conference's even being held. I'm appreciative because as a police officer I know that we have traditionally dealt with violence as a criminal justice problem rather than a health problem. I personally believe that the 1985 Surgeon General's Workshop on Violence and Public Health and this conference are both historical. We have a serious homicide problem in this country, with some 23,000 deaths occurring each year.

We have little national data on Hispanic homicide. For the five-state southwest region, which has more than 60 percent of the Hispanics in our country, the data show that from 1976 to 1980 the homicide rate for Hispanics was 21.6 percent per 100,000 population, or more than 2.5 times that of the white population. We need to determine what is the relationship between social class and the behavior of young males, what it is about the Hispanic working class that leads to homicide, and what distinguishes the majority of Hispanic young males who do not get involved in homicide from those who do.

From looking at data for Houston it seems to me that most minorities are killed not in the commission of some crime or while involved in drugs, but by people who know them. And I see no evidence to suggest that there are any innate biological factors involved in minority homicide. There is strong evidence to suggest a relationship between social, economic, and cultural factors in minority homicide. Minorities' relative degree of deprivation in society places them under more pressure, both psychological and physical, and the result is a higher level of frustration, which ultimately may lead to higher rates of homicide. There is evidence that shows a statistical correlation between unemployment and homicide and other evidence that shows a positive connection between homicide and the business cycle. A recent review of ten years of research on the relationship between violence and the media, particularly television and human aggression, shows some relationship between the two. All the data suggest clearly that the ready accessibility of handguns is a factor that cannot be ignored when we talk about the problem of homicide.

So what can we conclude? All this suggests is that homicide in the minority community must be considered as more than just a policing problem, more than just a problem for the criminal justice system.

[Judge Kinkeade introduced Dr. Paul Blackman, research coordinator for the Institute for Legislative Action, the National Rifle Association. The text of Dr. Blackman's talk is reproduced in its entirety as the paper entitled "Criminal Homicide and Assault: A Criminological Perspective" in appendix C of this book.]

[Panelists were asked to summarize their remarks of the previous day and give suggestions for future action involving data collection and research.]

Dr. Deborah Prothrow-Stith: Teaching conflict resolution has become part of the curriculum of Boston high schools. Role-playing a fight is one aspect of the curriculum. The students are asked to create a fight situation and the fight is videotaped and analyzed. The Jeremiah Burke High School has participated in a three-year evaluation of the curriculum. The data on self-reportive behavior show the number of fights in the school are down. A tenth-grade health course is mandatory in the Boston public schools. We've learned that conflict resolution is an appropriate subject matter for health education within the high school and that students do feel vulnerable to the problem and are enthusiastic about discussing it. In the future we plan to study the impact of this curriculum on individual behavior.

We have learned that students within the context of the classroom may buy into this new ethos, i.e., that the hero is not necessarily the violent person. But survey data suggest that most of the fighting occurs at home. We've got to begin to reach parents, community leaders, human service providers, and health-care providers. Within two neighborhoods, Roxbury and South Boston, we have met with the clergy, priests, police, schools, and community agents. The goals of the program are 1) to network with human-service providers and have them get out the message via radio, billboards, etc. that the hero doesn't have to fight; 2) to provide education in other areas; and 3) to develop an access system, a number for persons to call for future services.

I'd like to mention one other prevention strategy. The view of violence as a public-health problem means that we're going to have to look at medical institutions as well. The hospital-based initiative currently involves identifying high-risk patients who are in the hospital and emergency room, getting profile data and adapting the high-school curriculum to do an intervention with these high-risk patients.

Dr. Paul Blackman: My concern with the public-health approach to criminology is that the expertise often means reinventing the wheel with more concern for making policy than for the accuracy, relevancy, or availability of the data to support a policy. You should test your theories before proposing a law. First, get the data; then decide if you need another law. In some foreign countries (Israel, Switzerland, and Belgium) there are lots of guns. Better research and more skepticism regarding research is needed. Don't believe shoddy research because the conclusion sounds nice. Treat research consistently and try to avoid tunnel vision. Avoid the rhetorical use of data as with crimes per second, hour, minute, or day.

What data should be sought and used by the public-health professionals? I think local studies are needed--urban, surburban and rural. Assault data--circumstances, motives, relationships, weapons, etc.--are something you all are in the best position to collect. There are other types of research which may be better for public health professionals than criminologists. Criminological studies have simply failed as yet to determine what portion of homicides were intentional killings and which were unintentional or what percentage of aggravated assaults were attempts to kill or to injure seriously or not really to cause any serious bodily harm. It's unknown to us whether a gun or knife is selected over less convenient, easy-to-use weapons because the intention is to kill or whether the motivation is to threaten or injure and death results simply because of the nature of the weapon chosen.

Researchers in public health and criminological professionals should be more concerned than they have been to date with the rights of individuals. This indifference has been a greater problem among public-health specialists than among criminologists, who at least recognize that laws aren't self-enforcing and that people are reluctant to serve as guinea pigs for experiments and social improvement.

The quality of life may require a certain freedom from government. If you have a reduction in the fear of crime by having a gun in the home, presumably to some extent you will have psychological benefits. Because it fails as yet to take psychological factors into account, the epidemiological model may be inappropriate for studying assault and homicide, especially since some advocates like the Center for Disease Control, have deliberately avoided hiring expert criminologists with knowledge on the relationship of guns to homicide and assault. I don't think you can really effectively study homicide and assault by either ignoring the criminological findings or simply replicating them in a more casual way.

Workshop

Rape and Sexual Assault

Moderator	Ann C. Maney, Ph.D., Branch Chief, Mental Health Resource Resource Policy Branch, National Institute of Mental Health, Rockville
Panelists	Jennie J. McIntyre, Ph.D., Associate Professor of Sociology, University of Maryland, College Park
	Sue Kelly James, M.S., Senior Staff Coordinator, Dallas County Rape Crisis Center, Dallas
	David A. Waller, M.D., Chief, Child and Adolescent Psychiatry Division, Southwestern Medical School, Dallas
Recorder	Lynn Hester, Doctoral Student, Texas Woman's University, Houston

[Dr. Ann Maney reviewed research currently sponsored by the National Institute of Mental Health on rape and sexual assault, including that of Dr. Saleem Shah on antisocial and violent behavior.]

Dr. Jennie McIntyre: In my talk today I would like to emphasize prevention and the ways in which women might protect themselves if and when they are faced with an assault situation. I have been asked whether teaching women to protect themselves isn't just putting the blame for the rape on the victim. Shouldn't the offenders have to answer for their actions? Most of the studies on offenders as well as programs for rehabilitation are geared to men who have been incarcerated for their offenses, and these represent a small proportion of rapists and are probably not representative of the kinds of men who rape. Certainly research on offenders must continue, but in the here and now, I believe we need to think about how the woman can protect herself. We can't always be with the people who would like to protect us, and we can't lead cloistered lives. The offender is truly responsible for his actions, nevertheless most of us would prefer to avoid being raped or injured regardless of who is at fault.

We now have information on rape prevention which is the result of systematic, careful research. One task that faces us is utilizing this information. We need to find ways of getting this information to women themselves through service providers, educators, workshops, etc. We should also consider how to provide this information to women in a manner that acknowledges that they might not be able to avoid rape. Although they can learn techniques of avoidance that are sometimes successful, women should realize that

they simply may not be able to prevent the rape and should not allow themselves to feel guilt after the rape.

This information should be disseminated to policymakers, law-enforcement personnel, and people in the justice system as well. Various myths about rape influence the ways in which all of these people deal with it. There are people who would argue that unless a women has injuries, she was a willing participant in the act. On the other hand there are police officers and others who argue that a woman should always comply with the demands of her attacker rather than take a chance of being injured. All of these people need to be informed not only about the limits on what women can do but also the possibilities that they may have for action to influence what happens to them.

There are elements in our belief system that tend to increase the number of rapes in the society. Diane Scully interviewed incarcerated rapists and found that their beliefs were very similar to those of the rest of the population in many respects. In particular, their notions of masculinity were consistent with the general view, only in an exaggerated form. They seemed almost to be overconforming to some notion of what masculinity or sexuality was about. They would say things like "Well, after all, that's what a woman's for. If she doesn't give it to you, you take it." They had a feeling of accomplishment after a rape.

We need to think about changing those elements of the belief system that have to do with encouraging rape, such as the attribution of blame to the rape victim. Television and other news media have a strong influence on these attitudes through the ways in which they portray rape. It has been suggested that we find ways of bringing up boys and girls without perpetuating these beliefs. A researcher at the University of California at Los Angeles found in questioning young adolescents on their sexual attitudes and stereotypes that both boys and girls expected that there would be some measure of coercion in normal sexual relationships. Certainly such ideas are conducive to date rape, for example.

Some rape crisis centers are taking responsibility for providing education in the community. The one in Washington, D.C., is talking to boys and girls in elementary and junior high schools, and trying to encourage boys to think of their masculinity in ways that are not conducive to rape. We might also think about bringing up girls in ways that encourage them to be more assertive, for example. The Eisenhower Foundation in Washington, D.C., has a project for teenage mothers. Mothers and their babies live in a residence where they are taught how to care for their babies and are given the support that will help them to do so. Another component of the project works with nonresident teenage mothers from the neighborhood. This is primary prevention; it is long-term and does not eliminate the necessity for protecting ourselves at the present time.

Our research consisted of interviewing a number of women who had been in an assault situation, raped or not, injured or not, to learn whether any variables could be said to lead to one outcome or another. We learned that an enclosed space or an isolated area reduces a woman's chances of escape. A woman in company with others, her children or a friend, for example, is more likely to go along with a rape to protect the others. She might fight a stranger harder than a friend or acquaintance. Looking at the sequence of events that occured in a rape, we found that if she was aggressive, his next action was likely to be aggressive. However, we also found that while the immediate consequence of resistance

was likely to be greater aggression or hostility on the part of the offender and an increased likelihood of minor injury for the victim, the ultimate outcome for the resister was more likely to be avoidance of rape. We also found that regardless of the victim's actions, the offender's hostility escalated as the incident progressed.

Sue Kelly James: Yesterday I talked about specific populations who were not getting their needs met by rape crisis facilities. These include adolescents, adult males, and the mentally retarded. Today I'd like to talk about how we can meet these needs.

For adolescents I think there is a problem with reporting acquaintance rape and "date rape." The credibility of the victim is especially low in such a situation, and she is often unwilling to risk disbelief. I also think that in our process of socializing adolescents we may be overly critical of them so that they don't feel the kind of support they need to be able to report a rape. Adolescents do seem more able to report incest; we have had a good reporting rate in that area.

The most difficult problem for adult males is dealing with the notion that when a male is raped by another male it has do with homosexuality. We need to help the public understand that this is a crime of violence, not a sexual event. We also need to deal with the feeling of an adult male who has been raped that he is less of a man because he was unable to protect himself. We need to get across the message that being vulnerable does not minimize one's masculinity; anyone can be a victim of a crime of violence.

In terms of the mentally retarded, I feel that sexual assaults on these victims are very much underreported. The Seattle Rape Relief Project had a two-year grant to work specifically with the handicapped in sexual assault. During that time they identified 300 victims, yet felt that these were only 20 percent of the victimized handicapped population. Handicapped victims are often exploited in the same way that children are, in that they don't know that something wrong is going on. They may be told that this is what special friends do or this is something new, a new game. Like children, they may be victimized by someone they know and trust, and they are protecting that person. The secrecy pacts used with children are also very effective with the mentally retarded. The Seattle Project succeeded in teaching mentally retarded students to avoid dangerous situations by repeated showing of visual aids depicting the same situation being handled in two different ways with appropriate outcomes.

[several minutes of silence on tape.]

We have managed to change other attitudes toward victims and perpetrators of violent behavior so radically over the past 15 years that I genuinely believe that we can also meet the needs of these special populations.

Dr. David Waller: Let me first describe the posttraumatic stress disorder and then talk about three theories as to how it comes about and treatments based on each of those three theories of etiology. The first feature is that there is a recognizable stressor that would evoke severe distress in anybody. This is characterized 1) by being outside of the normal

experience of life and 2) by the threat of loss of life for the person who experiences it. The second major feature is a re-experiencing of the trauma, by recurring and intrusive distressing recollections and dreams, sudden acting or feeling as if the traumatic event were recurring, and intense psychological distress. The third criterion has to do with the numbing of responsiveness to the external world, markedly diminshed interest in activities, feelings of detachment from others, etc. The final criterion has to do with persistent symptoms of increased arousal, such as a startle reaction, trouble sleeping, or hypervigilance. All of these features have to occur in the same six-month period. This entity seems to hold together to some extent as a clinical disorder no matter what the particular trauma happens to be. I think that the rape trauma syndrome that Burgess described is an example of this disorder; and the importance of research into this in terms of sexual assault is that individuals who have had the most severe and long-lasting reactions to sexual assault can be seen to have a chronic and severe form of the post-traumatic stress disorder. Once we recognize that this is an important clinical entity we can learn a lot from other studies of this disorder that may not have to do with sexual assault.

The first and classic study of this disorder was by Dr. Abram Cardener some 45 years ago. Let me read a few of the statements he made which I think have special relevance for sexual assault.

> Although there is no such thing as a specific neurosis of war, those of a similar character that occur in peacetime are swallowed up in oblivion.
>
> No one exposed to the war experience comes away without some of the symptoms of the traumatic syndrome, however temporary these may be.
>
> The reaction to impending threat of destruction is the pathological nucleus around which a new style of adaptation is organized. This new organization constitutes the disorder.

I think this is a very important issue: that the disorder consists not of the person's being disorganized but rather of a particular kind of adaptive organizational response to the threat of death. This diminution of interest in the outer world is usually the result of a long, unsuccessful battle to maintain meaningful contact with the world. The subject suffers from a kind of delusion that the world has become an unbearably hostile place. A defensive attitude chokes off the possibility of further pleasurable outside contact.

How do we understand the etiology of the disorder? There are basically three theories as to how it evolves that I would like to describe briefly. The psychoanalytic theory suggests that there has been an extensive breach in the protective shield against external stimuli. There is a need to drain excess energy. By repeating the trauma in dreams and in waking life, the individual transforms the passive victim's stance into an active, coping mastery stance.

A second way of understanding the syndrome is based on learning theory. Pavlov wrote that the conditioning of this reaction to potent environmental stimuli results in the subsequent experiencing of the trauma over and over again. The general finding is that after repeated aversive stimulation the cues associated with the trauma become capable of eliciting the defensive reaction by themselves. An example of this would be the Vietnam

veteran who hears the sound of a passing helicopter. This can re-elicit the experience of combat as many as 15 years after the original association was forged.

A third model is biological. In 1985 Vandercaulk and Colies reported on a psychobiological theory of post-traumatic stress. There is an experimental animal model for this disorder. An animal exposed to inescapable shock experiences an initial depletion of norepinephrine, a hormone that assists in transmitting nerve impulses, and this is used to explain the numbing, lack of motivation, and inadequate response to the environment. That is followed by an intense supersensitivity of the system such that any response to external stimuli is overdone; this explains some of the hyperarousal state that is seen.

What are the treatment implications of each of these? Let's start with the learning theory. Dr. Calvin Frederick invokes incident-specific treatment based on the idea of relearning. You have an individual who has learned to have an inevitable stress reaction to certain kinds of stimuli which as a result of the assault have come to be associated with it. He believes that the only procedure that resolves this type of disorder involves a frame-by-frame, slow-motion reworking process. In some instances he feels it may even be necessary to return the subject to the location of the catastrophe. There is danger that the person can be overwhelmed, and the procedure must be done with an extraordinary amount of care, support, and sensitivity. This is basically a kind of psychologic immunization that enables the person to release his or her learned response to the stimuli so as to be able to experience once again those circumstances without a stress response. The normal tendency of the subject to avoid the circumstances that brought on the disorder make it unlikely for this deconditioning to occur outside of therapy; and it is important to help a person deal over and over again with what has happened despite the avoidance factor that is a part of the syndrome.

The psychodynamic theories were summarized recently by Dr. Debra Rose. She points out that in the kind of traditional psychoanalytically oriented psychotherapy that is done, the transference reaction that occurs is actually extremely important in helping a person resolve the post-traumatic stress disorder. In the theory of the transference, a person re-experiences with a therapist feelings that were held in another relationship outside the treatment. Whether intended or not, this is the process that almost invariably takes place. According to Dr. Rose, the victim of sexual assault will tend to experience on some level the therapist as being like the rapist. This is probably the reason that treatment of this sort is rarely initiated or ends abruptly. There are many forces at work to make the therapist and patient withdraw from such a relationship; yet this can provide the most useful focus for treatment because it crystallizes in that interaction the necessity for the person to confront those kinds of feelings that are preventing him or her from getting directly involved again with people. If those transference issues can be resolved, there is hope of resolving the post-traumatic stress disorder in this manner.

A third avenue of treatment would be based on the biologic model. It is interesting that the inescapable-shock, experimental animal model for this syndrome has also been used as a model for depression, the so-called learned helplessness state. Experimental studies have shown that animals can be helped to learn again to have a positive outlook towards their environment once they no longer feel that they are in a helpless situation. This

has led to the hypothesis that there may be a role for antidepressant medicines in the treatment of the post-traumatic stress disorder.

In summary, then, I think that now that this disorder has been defined as a psychiatric disorder it becomes possible to research such issues as why it is that one person who goes through a sexual assault experience develops this syndrome and has a persisting problem with it, whereas for other individuals it is not as severe or as long lasting.

Plenary Address

Homicide and Assaultive Violence

Address Keith Harries, Ph.D., Professor of Geography, University of Maryland

Dr. Keith Harries: A couple of years ago my colleague Steve Stadler, a climatologist, and I were speculating about the effects of thermal stress, hot weather, on behavior, particularly criminal behavior. Given my interest in the geography of crime, his expertise in physiology and climatology, and the lack of research on this topic we decided to explore the issue further. Developing hypotheses on the basis of prior work and clinical psychology we decided to use Dallas as a site for analysis and the extraordinarily hot summer of 1980 as our time period.

I should mention some caveats. These findings are based on police department data, in other words, on reported incidents. For homicide the tabulations are reasonably complete, but we can assume that the assault data reflect significant underreporting. The second caveat is that the data upon which this discussion is based do not permit the identification of victim/offender relationships or of ethnic affiliation. Furthermore, suspect information has had some technical problems associated with it and is in the process of being reworked. Except by inference from location or weapon we are not able to discriminate between types of homicide or assault.

Nicholas has suggested that several factors have produced a focus on offenders rather than victims. First there has been the natural law-enforcement interest in offenders; second, police departments have not usually regarded serious violence as preventable; third, attention in psychoanalytic theory has focused on the offender; and fourth, considerable interest has been directed over the last decade or so to cultural interpretations of violence, particularly homicide. Few studies have looked at more than one mode of violence at a time, and few deal with violence at both the individual and environmental levels. Our study attempts to fill some of these gaps.

High levels of homicide are extraordinarily persistent in the South over several decades. On the basis of a population of nearly a million in 1985, Dallas reported 301 homicides and 6,800 aggravated assaults, or rates of about 30 and 688 per hundred thousand respectively. This homicide rate of 30 compares to a national rate of about 8 for the same year. The assault rate of 688 compares to 303 nationally; so the Dallas homicide rate is around 4 times the national rate, and its assault rate more than double. Let me stress again that this is to be expected given the historical geography of violence in the United States; however the fact that it is predictable serves to focus our concern and leads to a series of questions seeking to explore the anatomy of regional and local variations.

The relationship between heat stress and violence is well established in folklore. It is tempting to speculate that the irritability universally associated with thermal discomfort could interact with other variables and emerge as a significant partial explanation of patterns

of violence. Some support for this notion was found in recent research in clinical psychology and we were encouraged to develop several hypotheses. Most basic perhaps is what is referred to as the "urban heat island," the differential of heating that leads to appreciably higher temperatures in urban settings compared to rural. We also felt that thermal stress would be mediated by population density on the ground that high density would provide enhanced opportunities for social interaction. The involvement of alcohol should be considered since summer heat would increase the likelihood of thirst which in turn would amplify the probability of consumption of alcoholic beverages. Another set of factors collectively called "calendar effects" included such phenomena as intensified interactions on weekends, seasonal variations in unemployment, and public holidays such as July 4th.

It was also felt that a neighborhood context would help explain variations in the incidence of violence. Neighborhoods were classified into three levels of socioeconomic status (SES): high, medium, and low, according to an index of urban pathology based on housing quality, race, and income. The resulting typology implies differential abilities to cope with various problems including heat stress. Availability of air conditioning--the principle technique for reducing thermal stress in indoor settings is a function of wealth, which in turn is correlated with race or ethnicity. In 1980 some 90 percent of all the dwelling units in the city of Dallas were air conditioned. However, over 95 percent of homes occupied by whites were cool compared to 83 percent in black-occupied dwellings, and 79 percent in homes occupied by Hispanics. According to the census, nearly 37,000 dwelling units in Dallas had no air conditioning in 1980. If this total is multiplied by the average number of persons per household in Dallas (about 2.5), it may be assumed that some 93,000 persons were living without air conditioning. Given the hot summers prevalent in Dallas, one may speculate that this lack of air conditioning for a large number of people may have various public-health ramifications. We hypothesized that low-SES areas would exhibit an exaggerated response to thermal stress as a result of interaction between the social and physical environments.

We selected 1980 as the year for analysis owing to the extraordinary severity of its summer. Several places in the Southern Plains experienced 40 or more days with temperatures exceeding 100 degrees F. The ambient temperature reached 115 degrees at the Dallas Airport and possibly exceeded 120 degrees downtown. The period March through October 1980 shows there was some apparent correlation between the daily incidence of assaults, the daily ambient temperature, and a discomfort index. A model containing a discomfort index, day of the week, and month as independent variables was quite successful in accounting for variations in daily assault frequencies. Even when placed last in the model the discomfort index was still significant, however the principal source of variation was day of the week. The mean frequency for Saturdays was 27 incidents compared to 14 on Tuesdays and Wednesdays. The anticipated exaggerated response of low-SES neighborhoods--the neighborhood context hypothesis--can be illustrated by a plot of the relationships between the assault frequencies, months, and neighborhood status. It can be seen that the lowest SES neighborhood had a sharply exaggerated response in August. The density hypothesis was evaluated through analysis of rate differentials

adjusted for different types of dwellings. Apartment based assault rates were exceptionally high in low-SES neighborhoods as shown in this comparison between population based rates and rates per one thousand apartment units. Calendar effects were very strong. The weekend effect was the strongest of all the macroenvironmental variables. Investigation and connection with the alcohol hypothesis shows assaults at alcohol related locations such as bars and bar parking lots to be more numerous than expected, particularly on weekends. Unfortunately, however, we were unable to obtain direct measures of the role of alcohol in individual cases so the alcohol indicator was unacceptably crude.

The next phase of this research is still in its exploratory stage and has involved some analysis of rates and patterns of both homicide and assault for the period of 1981 through 1985. This discussion will be couched in terms of patterns that are temporal, demographic, and related to place of occurrence and weapon use. Eventually it is hoped to add other dimensions to the data base in order to look in greater depth at thermal stress and other questions. One of the issues that has been of interest is a comparison of patterns of homicide and assault in order to reexamine whether or not they are essentially the same behavior, differing only in outcome. This issue, explored in the work of Pittman, Handy, Pokorny, and others, can be examined in some detail given the substantial time span available for review here. The data set added for the present analysis consisted of some 1,200 cases of homicide and 32,000 cases of aggravated assault over the five-year period, the longest continuous series available at the time that I addressed the request for data to the Dallas Police Department. Tabulations recently provided by the Dallas Department of Housing and Urban Rehabilitation reconcile data from the 1980 census to the typology of areas used in the heat-stress studies in order to permit verification of the validity of that typology, which was originally based on empirical data. The classification was shown to be robust and analysis proceeded on the basis of the same geographical framework with low-, intermediate-, and high-SES composite neighborhoods. The new data also permitted the calculation of population-specific rates which had not been feasible previously due to a lack of detailed current population totals reconciled to the spatial typology. What is new here is that the previous studies have usually dealt with spatially aggregated events. Here the incidents are disaggregated to the three levels of the neighborhood typology. As noted earlier, this is a victim-based analysis and I am currently missing data on offenders, including material relating to victim/offender relationships.

If we summarize and compare seasonal characteristics in a more generalized format on the basis of percentages of incidents occurring in each neighborhood type by season, we see mildly higher proportions of homicide for each SES level in the summers and a somewhat sharper difference for assaults over the five-year period. This difference has not been rigorously tested for significance but suggests that increased social interaction and thermal stress phenomena in the summer have very similar if not identical roles in both homicide and assault. When we examine the weekend phenomena, we see no consistent pattern for homicide by SES, although we do see larger percentages of incidents on weekends in the medium and low-status areas. The pattern is more clear-cut for assault; it shows higher levels of assault on the weekends at all three levels of the typology. There is

a bulk of incidents occurring between 4:00 p.m. and 4:00 a.m., with 8:00 p.m. to 4:00 a.m. accounting for the largest share.

I'd like now to consider briefly demographic relationships. For homicide, we see a remarkably consistent stair-step effect for each age group as a function of SES. In all cases, rates increase as SES declines: in the 25-to-34 age group in particular, the level of rates in the low SES is exceptionally high, on the order of three times that of the medium-SES areas. No other age group shows quite such an exaggerated difference. A similar relationship holds with respect to assault, not only with regard to the consistency of the stair-step effect, but also in relation to the exaggerated rates for the 25-to-34 age group in the low SES. Again the rate vis-à-vis the intermediate level of SES is about three times greater. Based on a percentage breakdown we find that assault is much more dominant in the 10-to-24 age group while homicide is much more important in the 35-to-64 range. This would appear to be one of the few sharp differences between the offenses. The homicide percentages are virtually identical to those described recently by Tauter and Gross of Manhattan, but the Dallas data differed considerably from those presented by Mercy and coauthors for Los Angeles. The principal difference is that about 10 percent more victims fall in the 25-to-34 age group in Dallas compared to Los Angeles. Analysis of population-based rates indicates that the Dallas rate in that cohort is about double that of Los Angeles, as is the rate for the 35-to-64 age group. How do the assault data compare to national norms? High levels of assault in the 10-to-24 and low rates in the 35-to-64 age group are consistent with the national victimization experience. So the differences between homicide and assault represented by this table are quite consistent with national norms. Clearly the differences are not due to the sizes of the age cohorts since we are looking at the same base populations for both offenses in Dallas. The explanation must lie in differentials in the underlying processes. One factor in the relatively low rate of homicides in the younger age group may be the distribution of firearms in this cohort. There are some poll data suggesting that younger persons are less likely to own guns. In the 1983 Gallup report 33 percent of respondents under the age of 30 reported that they had a gun in the house. The percentage increased to 44 for the 30-to-49 cohort and to 45 percent for those age 50 to 64. Another contributing factor may be differentials in the mix of expressive violence versus instrumental violence.

Racial characteristics of victims tabulated by SES show that percentages are very similar across offenses by race and they are conditioned principally by the racial composition of each SES type. Data on the sex of victims suggest some differences by offense types across the SES levels. At lower levels of SES, females were less likely to be homicide victims, males more likely; however assault involvement was fairly constant across SES categories. The markedly higher levels of male violence are consistent with national norms which showed up for all types of violence, male rates are about double those of female victimization. The Dallas experience is broadly comparable to the interpretation presented by Mercy from Los Angeles and to the New York data of Tauder and Gross. A cursory look at the land uses where incidents occur, by neighborhood SES and offense category, showed that compared to assaults, homicides were much more likely to occur in apartments in the high-SES areas. Locations were more diverse for assault as

compared to homicide: residences accounted for some 60 percent of homicides but only about 50 percent of assaults. At the medium-SES level, residences accounted for 40 percent of homicides and around 30 percent of assaults. In the low-SES areas, residences were the site of roughly 40 percent of the incidents in both crime categories. In all three areas streets were more likely to be the scene of assaults. This would tend to confirm the impossibility of preventing homicide, directly at least, given the privacy of site of so many incidents. However, assault would appear to be a more public phenomenon and to a limited degree more amenable to surveillance and prevention. When we look at the distribution of firearms, the anticipated dominance of firearms in homicides was evident across the three neighborhood types. In general some 70 percent of the homicides involved firearms and about 20 percent knives in all three areas. Several observations would appear to be appropriate from a public-health perspective. First, the persistent evidence for a thermal stress effect suggests that public health and law enforcement agencies should expect marginally higher rates of violence during periods of unusually high temperatures. Given the relative lack of air conditioning in the dwellings of those most likely to be the actors in incidents of violence, it seems possible that the provision of air conditioning could have a marginal effect in reducing violence. Since there are no reliable data on the relation between the sites of incidents and the availability of air conditioning, this suggestion must remain speculative at least for the moment. We have seen that assault and, to a lesser degree, homicide are subject to pronounced seasonal variations. This suggests the need for agencies to plan for valleys in attempting to prevent and deal with the consequences of violent incidents.

Second, considerable evidence both here and in prior work suggests that homicide and assault are secondary products of a single behavioral continuum of violence. Indeed as Roy Allen has recently noted, the weapon used and the effectiveness of emergency medical services may be the most powerful determinants of lethality. It may be more appropriate in our dealings with violence, then, to regard interpersonal violence as the primary category with homicide and assault as secondary labels. In preference to the customary practice of regarding each offense as a discrete category of behavior, a more comprehensive and useful picture of serious violence may be obtained by viewing the issue on the basis of a unitary model of data collection and analysis. Such a holistic view will permit an all-embracing assessment of public health impacts including costs of incidents, effectiveness of law enforcement interventions, severity of injuries, and need for differential levels of preparedness according to the characteristics of neighborhoods.

Unless the geography of violence in the city is understood in some detail--and that detail should be both qualitative and quantitative--there is a risk that responses and interventions will be inappropriate to some degree. Given that those able to leave inner cities by virtue of economic mobility are tending to do so, it is possible that a qualitative change is occurring in violence, and one may speculate that it will become more instrumental as inner urban deprivation intensifies. For example, violence may tend to diffuse in previously uncharacteristic fashion as inner-city businesses close, reducing local robbery opportunities and increasing likelihood of predatory excursions into adjacent neighborhoods.

Third, it appears, at least in Dallas, that low-SES areas are more lethal environments with more assaults involving firearms and knives compared to higher-status areas. This and other negative attributes attaching to the low-SES areas imply the need for special treatment of such neighborhoods. I am an advocate of the concept already so capably pioneered by Dr. Debra Prothrow-Stith of antiviolence education, an effort to change values and modes of conflict resolution in low-SES areas. The type of analysis presented here, emphasizing as it does differentiation between areas, could help sharpen the focus of resources on those neighborhoods or city blocks where the need is greatest. I very much hope that the regional data collection system set as a long-term goal of this conference will indeed materialize and that the data system will also be a geographic information system, permitting the integration of the geography of violence with the census and other appropriate geographic data bases.

PART V

- ◊ Suicide
- ◊ Injuries Due to Risk-Taking Behavior

Workshop

Suicide

Moderator	Jeffrey M. Davis, M.D., M.P.H., Chief, Maternal and Child Health, New Mexico Department of Health and Environment; Assistant Professor of Pediatrics, University of Mexico School of Medicine
Panelists	Douglas Puryear, M.D., Associate Professor of Clinical Psychiatry, Southwestern Medical School and Director, Psychiatric Emergency Services, Parkland Memorial Hospital
	Phil May, Ph.D., Professor of Sociology, University of New Mexico
	Charles F. Vorkoper, A.C.S.W., Private Practice, Dallas
	Judie Smith, Director of Education Services, Suicide and Crisis Center, Dallas
Recorder	Chris Seldin, Doctoral Student in Psychology, University of Texas Health Science Center at Dallas

Dr. Doug Puryear: I have been asked to talk about our combination of crisis intervention and assessment. I think our risk-assessment parameters are fairly standard. The important thing is that while we are assessing these parameters, we are also doing crisis intervention. The parameters give us a scale with which to measure the degree of risk this person is in, in terms of those risk factors. But then we have to consider the degree of success of our intervention. Someone who may have very high risk factors may be able to be safely sent home if we have been successful with the intervention, whereas somebody with lower risk factors with whom we haven't been able to get to first base may have to be put in the hospital. For example, let's consider a 39-year-old man who has been out of work for 8 months. We are seeing him after a moderately serious overdose and have worked with him and his wife now for about three hours. During this period we have talked to his mother's doctor in another town and learned that she has terminal cancer. He was wondering and agonizing about this when he came in. We have also called his former employer and

learned that there is no way he will be rehired at that job, but that they will write him a good recommendation if he applies for another job. We diagnose a genuine depression and put him on medication, which we explain to him will be administered by his wife to protect him from any recurring suicidal urges. We make another appointment for him and encourage him to call the suicide and crisis center if he finds himself in another of these black pits of despair. We prepare him for the probability that he will get a lot of busy signals from the crisis center. He has had some car trouble and we ask him to alert a neighbor that he may need help getting back to us for his next appointment. Part of our technique is to get as many people involved as possible. We assign him some very minimal tasks of daily life, acknowledging that in his state of mind he shouldn't attempt anything very grand. If at the end of three hours he has not seemed to respond to any of this, then we may put him in the hospital.

One of the key elements of suicide is a narrow, restricted focus. They restrict themselves to two options: either I get my job back today or I kill myself. Part of the job is to break the walls of that rigid tunnel vision and help them begin to see that there are some other options. We don't have to solve the problem; we just have to make the situation tolerable.

How responsible are we in preventing suicides? Is intervention always indicated? Opinions vary widely on this. I feel that whether or not we choose to hospitalize or to initiate the process I have described to you, our interactions with a client constitute intervention, and we should maintain a sense of our responsibility in all these interactions.

My final comment is on the issue of hopelessness. Part of our assessment is to check people for investment in the future which is the opposite of hopelessness. If a patient can visualize how his life might be in five years, he has investment in the future. My favorite example of this is an occasion on which I was interviewing a young female patient to decide whether we were going to have to put her in the hospital or could let her go home. I said to her, "If I let you go home like you want to, would you be willing to come back Tuesday and see me? Because I would like to see how you are doing. If you go home this afternoon would you be willing to come back Tuesday?" She said no; she couldn't do that. And I said, "Oh, why not?" "Well, we are going to be taking inventory on Tuesday." So she went home.

Dr. Phil May: Yesterday I went over two studies of several tribes of American Indians spanning a period of more than twenty years. I will review some of the main points I tried to make. Basically, the Indian suicide rate varies tremendously from one tribe to the next, as well as from one era to the next. Tribes may have high rates over one decade, and low rates over the next. Second, American Indian suicides are predominantly male--nine males to one female in New Mexico. My third point was that American Indian suicide is particularly among the young. Most American Indians who take their lives do so before the age of 45, with high rates in the categories of 15-to-19 and 20-to-24 years of age. That runs across all tribes, even if the tribe has a low rate.

My final point was that we have seen suicide increase in New Mexico. In the late fifties the suicide rate in New Mexico was three times that of the general population in the

United States, and over the 23-year-period to 1980 the rate grew virtually at the speed of the overall U.S. rate in those age categories.

We have three goals in dealing with suicide: primary prevention, education, and crisis intervention. First, we need to enhance people's quality of life so that they are exposed to fewer of the problems and frustrations that breed violence, on and off the reservations. (According to the 1980 census less than half of all Indians in the United States live on reservations.) So basically one of our primary preventive modes, as in all societies, is to improve socioeconomic conditions, life conditions, and people's coping skills. Second, one thing that we have not done very well in Indian country, as a lot of small coummunities have not, is to face the problem with our young people and do concerted health education with various populations at risk. There are several novel programs in New Mexico that deal not only with aspects of Indian suicide but also emphasize coping skills, self-esteem, and so on. Third, we have to have a crisis-intervention approach. I'd like to talk about three of these that I've been involved with over the past sixteen years. The first was in Fort Hall, Idaho, a Shoshone Bannock tribe, recognized in 1960 to have a severe suicide problem among the young people. Prevention efforts were initiated almost solely by the tribal council, which renovated an old Bureau of Indian Affairs house into what they called a holding facility. It had been noted that the majority of the people who were killing themselves had come into contact with the law-enforcement agency previously so they had a beautiful intervention variable, that is, virtually all of the victims were spending time in jail. To staff the holding facility, they established a tribal volunteer system in which average citizens, generally elders, made themselves available on a 24-hour basis. When a child was recognized to be at risk by the police or by the school, the volunteers were called in to stay at this holding facility with the individual for as long as they felt was necessary. They had backup of psychiatrists, social workers, general clinicians, etc., and it worked very nicely for them. The Ft. Hall suicide rate was reduced by over 50 percent in the next decade and there were several years in which no suicides occurred. The tribe also used this political action to acquire new housing, and they took advantage of community action program grants for new tribally operated businesses, all these things creating a more positive life force in the entire community.

The second crisis intervention program I was involved with was in a hospital in Pine Ridge, South Dakota, with the Ogalalla Sioux. In the early 70s we had a significant problem with suicide there. The suicide pattern at Pine Ridge was different from that at Fort Hall in that instead of violent means, the prevailing method of suicide was drug overdose. So the medical model was totally appropriate for this community. We set up a 24-hour call system based out of the hospital emergency room. At that point, we were the only community mental-health program in Indian Health Service, and we had a good mental-health staff. Members of our staff went out into the community and did a lot of police training, and teacher training in the schools. We had extremely active community-health representatives, and anyone who was making significant threats and/or attempts at suicide was brought in and seen on a 24-hour basis.

The third program I would like to talk about combines aspects of the previous two, some tribal initiatives and some health-care initiatives. The New Mexico program is an effort to serve two Pueblo tribes who seldom see eye-to-eye for historical reasons and a Navajo tribe who has a completely different culture from that of the other two. We have suffered many failures with this program, but one positive thing that has come out of it is a strong preventive-education initiative in the high school. A program called "Teen Center" has been initiated there which has opened up a lot of health education and other resources for the young people.

I think these examples show that the ideal approach needs to be multifaceted in the first place and tailormade, in the second place, for the community it is to serve.

Now, on new research: it is often said that you can't do research with American Indians, but we have found that policy research done in conjunction with tribal officials, many of whom are very well educated, can be very effective. Although accidents have been the leading cause of death among American Indians for as long as we have been keeping data (since 1955), only 11 studies, 8 of which are published, have been done on the subject of accidents in the American Indian population, mostly clinic and emergency-room studies. Only about three involve actual highway statistics. There are about 40 published studies on suicide among American Indians, with only one control study. I believe there are two published studies on homicide, which is slightly higher per tribe among American Indians, than in the general population. We need more research in all of these areas. Specifically, I would like to see a major study on how all these things interface. One type of research could focus on families that manifest all of these behaviors. A second thing we need to do is look at the success stories. Many people have made it out of these socioeconomic conditions and attained professional success. What factors can we identify that allowed these people to cope while others failed? Third, we need more epidemiology on all the behaviors we've been talking about. In our suicide studies we had to use four and sometimes five sources from birth to death to figure out who was an Indian and who wasn't, Fourth, Robert Havinghurst, noted in 1971 that American Indian women have an extremely low suicide rate, not only compared to the Indian male, but in many age groups. Why? Nobody has looked at that and it is a fascinating thing. The same is true for American Indian elders. Why? It could be that all those at risk have succumbed by the age of 45, but why do American Indians have extremely lower rates in the elder years and, actually, a longer life expectancy after 50 years of age?

Charles Vorkoper: I am concerned with the epidemic nature of suicide and the way that the press can make the situation worse by how it handles suicide stories. One of the major papers in Houston reported a recent multiple suicide by publishing the pictures of all the students with descriptions on the front page of the paper. I think this is irresponsible journalism. Efforts need to be made toward educating the press and the public about the nature of suicide, and we need to offer information about other resources to individuals who are suicidal. This is a way of giving them an option to suicide which opens the constriction, the narrowness of focus that suicidal people suffer from.

I am increasingly concerned about the training of therapists around the issues of suicide. Sometimes when I talk to my fellow therapists about crisis intervention they say "What? That's what they do at the hotline." This is an unfortunate gap in the training of many therapists that I run into. I am also concerned about suicide among therapists. If there is one death by suicide of any therapist anywhere it is a serious matter. Training of therapists should include an invitation for them to get their own therapy.

Physicians should also be targeted for special eduction in suicide. They are contacted prior to many suicide attempts and are often not equipped to recognize a suicidal person.

It is important to recognize that suicidal individuals are for a brief time in their lives dangerous to themselves and to their surviviors indirectly, but that they are intervenable and that they can go on living, that therapy works, and that informing people about suicide makes a difference.

Judie Smith: Yesterday I talked about two research projects on the effects of TV programming on the increase of incidences of teenage suicide (Gould/Sheffner and Philips). I think we should come out of this conference looking at strategies in three different areas: research, education, and service delivery.

In the area of research, the first thing that comes to my mind is a coordinating body or commission that would bring together all the disciplines that are interested in the field of suicidology: physicians, sociologists, clinical and developmental psychologists, etc. Within that we might want to investigate the effects of TV programming before we act so rashly as to accept these two studies. These are very sound studies; however, we had someone saying that one of them was duplicated in Texas and found no increase in suicide as a result of the same TV programming. We need to know more about this before it is allowed to have an effect on our school suicide-prevention programs.

A major issue in this field is the data collection system itself, and a commission could accomplish what all the agencies in this country have not been able to do, and that is get some good hard data. For instance, I am frequently asked, "What is your suicide rate in Dallas?" I don't know anybody who has figured out what the rate is.

One thing that we have heard over and over is the effect of loss. I have yet to talk to a suicidal client for whom loss was not an issue; be it from a death, separation, divorce, a loss of self-esteem, loss is there. I don't know of much research that tells us how these losses impact young people: what age, what kind, etc. This is another possibility for research.

Now, under the heading of education, one thing that is happening in school suicide-prevention and community-awareness programs is that the American Association of Suicidology is putting together a project called "Wingspread." They are going to develop a model school suicide-prevention program that will be available for school districts to use.

A goal that I have in education is to encourage every school district to write policy and procedure with regard to suicide. The Texas Legislature commissioned a group to make studies in this area, and one of the things they investigated was providing funding and encouragement for suicide prevention. In their survey of 1,000 school districts in the

state of Texas, they found perhaps one district with an acceptable written policy on suicide. It is not a matter of *if* you have a suicide in your school district, it is a matter of *when* you have a suicide. To postpone making decisions and figuring out what needs to be done within that school leaves a district vulnerable to the emotion and fear that accompany a tragedy.

The third area is service. Our crisis center has a professional staff of 6 and a paraprofessional staff of around 100. These counselors have 90 hours of training before they are certified. We have 15,000 clients every year, which is a lot of service. The amount of service we provide on a given day is limited by the number of volunteers we have; if we have four counselors working we have four crisis lines busy. We offer preventive measures through our educational services and intervention through the hotline at the center. The postvention part of our service is our Survivors of Suicide group, one of the most satisfying services that we offer. Because these survivors are experiencing extreme loss with tremendous anger and guilt, they are at a very high risk for suicide themselves, so that postvention turns into prevention, and it is a very legitimate part of a crisis center. We are one of the first centers in the country to offer this kind of service and we have had it about seven years. We separate adolescents and adults into different groups because we find that adolescents aren't comfortable with their parents and outsiders in a group. When a school has a suicide we would like to go in and form a group right then and there for those close peers that are at a high risk. If they have had problems themselves, then they may imitate that behavior. And speaking of data collection, there is no suicide reporting system in the Dallas school district for attempted or completed suicides. They don't know what their problem is because there is no avenue of reporting to any kind of central location. The only way they know of a suicide in a family is that somebody comes and tells them.

Another thing that I would like to see happen in service delivery here is immediate outreach. If there is a suicide in this community, there has to be an investigation by the police and a field agent from the county police of course. Let us say that a spouse commits suicide and the surviving spouse is there alone to deal with the police and field agent. I would like to see us have an outreach team to help that individual work through the grief process in these few moments immediately after the suicide.

The teenager is where our heart goes; it is a tragedy if a young person commits suicide. But the highest risk group is the elderly, and less than 1 percent of our clients at the crisis center are over the age of 65. The present modes of crisis intervention do not reach this segment of our population. We have to be more assertive in reaching out to them, because they are not crying out for help. They are much more likely to complete suicide on that first attempt. As our society ages, people are going to live longer. This will be an increasing problem for our society, and we must begin to turn our attention toward the elderly.

I say that suicide is preventable. I am convinced that suicide is preventable in by far the majority of cases, because suicidal people don't want to die. I think we spoke very clearly today to the fact that ambivalence is one of the most important things to understand about people who are suicidal. Because of that ambivalence, they are going to communicate that conflict as a way of reaching out. To say that someone wants to escape the present pain

that existence brings to them is very different from saying that they want to die; and even though you may hear "I want to die," we must understand it is escape, egression, that they are really aiming for.

Workshop

Injuries Due to Risk-Taking Behavior

Moderator	P. Clift Price, M.D., Associate Commissioner for Personal Health Services, Texas Department of Health
Panelists	Ron J. Anderson, M.D., President and Chief Executive Officer, Parkland Memorial Hospital
	Martha S. Williams, Ph.D., Dean, School of Social Work, The University of Texas at Austin
	Arthur S. Funke, Ph.D., Chief Psychologist, Division of Maternal and Child Health, Bureau of Health Care Delivery and Assistance, U.S. Public Health Service
	Michael E. Cavender, M.Ed., President, Dallas Challenge, Inc.
Recorder	Petty Officer First Class Dan Farris, Naval Air Station, Dallas

[Moderator Dr. Clift Price summarized briefly the session of the previous day. Risk-taking behavior is yielding the highest toll of violence in adolescents and youth. Stresses that induce this behavior include peer-group pressure, drug abuse, TV violence, depression, and abnormal family dynamics. Panelists were asked to give suggestions for future data collection efforts.]

Dr. Ron Anderson: Injuries from violence should be thought of as preventable illnesses. Cancer and heart disease are not presently the number-one takers of human life and productivity; accidents are. We need to address accidents from an epidemiological point of view, from an interventionist point of view and not simply assume that they will happen. Accidents are the leading cause of death of children aged zero to fourteen; the mortality rate of adolescents is actually going up. We have a major public health problem.

Since our emergency facilities have improved so greatly, especially the paramedic wagons, many people who didn't used to survive are getting to the hospital, and we know more about trauma than we did before. We have a trauma registry and we are getting information. One of the things I hope we can do in this next legislative session is to fund a trauma registry for the state of Texas and participate with southwestern and southern states to develop a network of trauma registries. It is critically important that we try to deal with underlying causes of these accidents (and sometimes nonaccidents) if we possibly can.

Trauma is a multidisciplinary area. We've always had surgeons in the special areas of trauma, burns, orthopedics, etc.; what we didn't have until recently was an alcohol-

intervention specialist. We have done studies of the incidence of alcohol and drug abuse based on our emergency-room data on major accidents and inflicted injuries and we find that abuse is substantial. Eighty-two percent of the victims of stab wounds at Parkland have high blood-alcohol levels, and 77 percent of our gunshot wounds are alcohol and drug related. Our multidisciplinary team now includes people who can do secondary prevention. A hospital that treats a broken hip from a motor-vehicle accident or closes a head injury from a motorcyle accident and doesn't address the underlying alcoholism is remiss, if not malpracticing.

Our studies have revealed that there is more chance of being shot with a bigger caliber gun before 10:00 at night, and therefore more chance of getting killed. Later in the evening people may get a little drunk and shoot with smaller handguns. In a study by Galbraith of the people who came to an emergency room because of aggravated assualt, 79 percent of the men and 52 percent of the women had alcohol in their blood. Forty-eight percent of all fatal car accidents in the Dallas County area have been alcohol-related and the leading cause of death in this community among 15-to-24-year-olds is driving under the influence of alcohol. If you look at DWI fatalities in Texas in 1984 the number was over a thousand, killing many more young Texans that did the war in Vietnam. The 18-to-34-year-old male, particularly, is prone to drive and drink heavily, as many as five stiff drinks of whiskey in one session. It is absolutely untrue that people who are drunk don't get killed. They are three times more likely to die than those who are not intoxicated. They are usually not buckled up, usually driving faster, and they have more disfigurement of the vehicle. Many drivers who had wrecks simply were unable to avoid the person causing the problem, but 91 percent of the intoxicated drivers involved in accidents were at fault.

More importantly, we are realizing that it is not just alcohol. Many people who are pulled over for unsafe driving may pass the Breathalyzer test for alcohol but are clearly impaired in their driving due to use of Quaaludes, valium, barbiturates, angel dust, and so on. Until we start doing toxicologic studies on these individuals we really won't know the precise impact of drugs other than alcohol. One of the most important drugs that we are not paying any attention to is cannabis, or marijuana. I said a minute ago that about 20 percent of the young men ages 18 to 34 thought nothing of driving after five drinks. Perhaps two-thirds of chronic cannabis users, who often say that they wouldn't drive and *drink*, feel confident driving under the influence of cannabis. They aren't aware that cannabis has a stronger effect than alcohol in the estimation of the time and distance. It has at least as much of an impact on braking time, maybe even greater on a dose-related basis. It decreases motor skills and balance and makes you tend to weave. You also tend to be depersonalized, you don't think anything will happen to you and therefore you have poor judgmental accuracy. Fifty-four volunteers who went through a cannabis driving-skills test reported distorted space and distance perception as much as twenty-four hours later, so people who smoke dope at night may not be fit to drive the next morning. We know that cannabis stays in the urine a long time. Another study looking at convicted cannabis users found that they had a high frequency of accidents over the preceding six to twelve months.

I would also like to say a word about cocaine. It is the "nice" drug; it is the upper, not the downer; the people in North Dallas use this drug. It is an all-American drug. But I

want you to know that many people die here from homicide with cocaine in their urine, as well as from motor-vehicle accidents, drownings, falls, gunshot wounds, etc. This drug follows violence and I think we ought to recognize that. Drug-pushing is not a victimless crime, and the people who bring heroin and cocaine to this country are dangerous criminals. It is a risk-taking behavior to be around drug traffic.

If I had one thing that I could do it would probably be to control alcohol. The cost to this country from loss of man-hours and productivity, health-care, incarceration, and property damage from alcoholism and alcohol abuse is $116 billion a year. I think it is important that we start addressing it and getting the data to see if we can't do something about it. It is going to require a dedicated public health intervention.

Dr. Martha Williams: Quite clearly the place to start in the search for countermeasures to prevent or alleviate any problem is to understand the cause of the problem in the first place. More than twenty years ago the National Highway Traffic Safety Administration launched multidisciplinary accident investigations (MDAI). MDAI teams of doctors, psychologists, social workers, economists, and others were assembled to describe the causes and associated injury-producing elements of traffic accidents. They looked at their sample of highway traffic cases in depth from three phases: before, during, and after the accident. Human factors, vehicular factors, and environmental factors were evaluated for their roles in accident causation and for their modes of interaction. Their findings verified what we have been saying--that the human element was the major factor (54 percent) involved in all of the accidents; environmental factors (weather conditions, road signs, highway engineering factors) and vehicular factors were recognized as contributing causes combined with the human factor but were rarely the sole cause.

Efforts to control the human factor in accidents have generally taken the following forms: 1) changes in the laws; 2) increased enforcement and sentencing; 3) mass education and advertising; 4) targeted education (at-risk groups); 5) treatment; 6) human-factors engineering; and 7) combinations of the preceding. The recent effort to increase the use of seat belts is an example of a multiple strategy with elements of several of the above efforts combined. Changes in demographics will change accident rates because different demographic groups differ in terms of life-style risk factors and in terms of their receptivity to intervention strategies. Efforts with the greatest chance of success are those targeted to specific groups.

Understanding of the human factors can provide information to help prevent accidents. People can be taught to make better decisions, even three or four minutes before an accident occurs, that would help to prevent it. One of the problems of alcohol and drugs is the way they affect the decisionmaking factors. Avoidance of alcohol and drugs and learning defensive driving skills are both effective accident preventers.

The kind of person most likely to be involved with accidents is basically an anxious, perhaps depressed, individual who behaves in a careless manner and commits errors, not only on the highway, but in the workplace as well. Research has continued to identify the accident repeater as suicidal, self-destructive, undergoing some recent or current life stress, or, more specifically, as aggressive, impulsive, psychotic,

nonpsychotically ill, depressed, anxious, and extroverted. Personal problems may be translated by an accident into a postaccident syndrome that is the more difficult to treat because depression and anger toward their own circumstances or problems are often translated into projected anger against the helping professional. That patient may simultaneously beg for help and refuse it and will often be reinjured in conflict. The accident victim differs from other victims of self-inflicted injuries in that accident victims have translated their personal problems into an acceptable disability.

Let me return to the other kinds of intervention strategies that I mentioned previously. First of all we have changes in the law, as has been done with the seat belt law and the drinking age. Then you have efforts that involve increased enforcement, different sentencing practices, or different kinds of enforcement. Chief Lee Brown of the Houston Police Department was talking about adding a more multidisciplinary type of intervention team in law enforcement. A third method is mass education or advertising. Targeted educational approaches can be used in such areas as the schools' driver-education courses, the workplace, the military, or wherever large numbers of individuals constitute a captive audience. This can be done either with a mass-educational apporach or by targeting specific at-risk groups within the audience, such as the teenage male. Then you have the clinical treatment approach for the alcoholic and the drug abuser, of course, and the human factor engineering approach, which is simply to try to deal with the design features of the roadway or the machine to make the environment safer. Perhaps the best solution will be a combination of these strategies, all of which have been shown to be useful. There is a lot of research now on what is called the ecological mapping model. Not only do you look at high-risk target groups demographically, but you also look at patterns within your community and target your strategy for those particular parts of the community that have a high incidence of violence or accidents.

Dr. Arthur Funke: It is remarkable that with all the recent growth in emergency medical facilities few states have adequate emergency medical services for children--trained personnel in the field and ambulance equipment specifically designed for infants and young children--that in any way compare to the assistance given adults. With that in mind Congress recently enacted a program to encourage states to develop such services specifically for children. In six months we hope to have twelve such state programs in existence.

I believe it is realistic to think about prevention in a long-range sense, not in terms of specific accidents, but in terms of developing a community that can eventually reduce its violence, its injury rates significantly. I think we have some good examples of this, and I was very pleased to hear Lois Herrington mention the success that she has seen in crime prevention. Her emphasis was on organization, on people living together, working together, addressing common problems and coming up with solutions to prevent these things from happening.

One of the things I would like to emphasize, from a point-of-view of maternal and child health, is the sort of thing we do with nutrition education in a community, not only educating parents about children's nutritional needs, but dealing with community attitudes

(i.e., restaurant food) as well, thereby improving over time the quality of our children's health. I like the metaphor of personality nutrition, improving the behavioral character of a family through emphasis on the kind of emotional nutrition that affects children's behavior, choices, risk-taking behavior, drinking, other choices they make. This is not something superimposed from the outside, but a way of helping communities look at their own problems, organize to deal with them, and make an impact on such things as crime prevention in the community.

Michael Cavender: Specific observed behavior which is inappropriate, unacceptable, and/or irresponsible and which causes you to be concerned is a "behavior of concern." You don't have to be an expert or a clinician; you may be a cafeteria worker, custodian, or schoolteacher. When you identify behavior of concern, you ought to be able to have a systematic way to refer that child for help. I would like to present a model for doing this.

We have a certified alcohol/drug-abuse counselor, but this can be any designated leader who receives these referrals. Although we want a drug/alcohol specialist on each of these teams to deal with these areas of concern, we don't just target drugs and alcohol. If we just talk drugs and alcohol, we limit the focus of the program. We want to target other psychosocial stressors. Our technique, called the "decision tree" is composed of two parts: 1) internal and external psychosocial stressors and 2) the consequences and the intensity of drug use. If we see we have a lot of external and internal psychosocial stressors with little or no drug use we know we can use a mental-health problem approach. If we have a high intensity of drug use and few psychosocial stressors we know we can use a substance-abuse approach. If we have both, then we must use a more intense type of treatment program. To facilitate decisionmaking, we evaluate each of the two areas--psychosocial stressors and drug use--on a three-point scale of low, moderate, or severe. If we see that the clients have severe psychosocial stressors and also moderate drug abuse, we think we can probably get by with family peer counseling or nondrug type treatment, the mental-health approach. When intense severe psychosocial stressors as well as severe drug problems are identified, it will probably be necessary to initiate residential long-term type of treatment.

We see many different types of families in our alcohol abuse treatment, some very enmeshed, too close, and others that are very disengaged. We see families that are chaotic and others that are overly rigid, as well as a mixture of the first and second pairs of characteristics (e.g., chaotically enmeshed, rigidly disengaged, etc.) We use a scale that enables them to figure out where they are by responding to questions and rating themselves.

I think parents do not know how to be parents because nobody has trained them. They need on-the-job training. I believe that the future of real prevention is parent education. We have to redevelop that trust relationship between kids and parents that we have lost because of the extended family and the mobilization of families.

We were getting a lot of calls from parents asking for help in decisionmaking: how late to let the sixth-graders stay out, when to allow them to start using makeup, etc. So we gave parents a questionnaire based on all their questions. We tabulated the results of the

survey and published them. This became a useful tool for parents. Now, when Johnny would come in and say, "Mom, everyone is staying out until midnight on Friday," mom would look over on the refrigerator list and she could say "No, I see that 82 percent are not." She has a frame of reference of social norms and could make a more educated decision. So intervention, prevention, treatment, active parenting: you can't leave one of those out. This is a low-cost, really inexpensive way to do it.

PART VI

- ◊ Learning from Patterns of Violence
- ◊ Regional Data Collection and Analysis
- ◊ The Costs of Violence and Its Impact on Future Legislation

Plenary Address

Learning from Patterns of Violence

Chairman — Joseph Warshaw, M.D., Professor and Chairman, Pediatrics
University of Texas Health Science Center at Dallas

Address — Mark Rosenberg, M.D., Chief, Violence Epidemiology Branch,
Center for Health Promotion and Education at Atlanta

Dr. Mark Rosenberg: Today I would like to talk about the relationship between research and practice in this area of violence. Violence breaks down into two types: self-directed violence, including suicide and other self-destructive behavior, and interpersonal violence, which can be directed at family, acquaintances, and strangers and is characterized by the relationship.

If you look at the history of disease and health problems in the world, you can see that problems that were thought to be facts of life turned out not to be so. Fifteen years ago smallpox was a fact of life; tens of thousands of people every year died of smallpox. Today there is no smallpox. I propose that we need to view violence in the same way. People mean well when they say that what we really need is a vaccine against violence like the vaccines we have developed against other infectious diseases; however, I think this reveals a logical flaw and leads to a negative reasoning. Since we know that violence is not really a disease and we can't develop a vaccine, this essentially says, "Forget it, what can you do about it?". I think a lot of people in public health traditionally view vaccines and medical technological interventions as having been more important in eliminating problems than in fact they really were.

The story about the fight against tuberculosis is an example. Around 1945 they developed a sort of immunization for TB, PCG. At about that same time they also developed chemotherapy and medicines that were effective against the disease. I ask you to guess: where do you think 1945 comes in relation to the decline in cases of TB? Some people guess at the very beginning. PCG and chemotherapy were developed almost at the tail-end of the change. The change actually began around 1836, more than one hundred years before these tools were developed. It was at this time that they began to understand that overcrowding, poor living facilities, and malnutrition were very important factors in the spread of TB. Without being able to treat the specific bacteria they made a big difference in the outcome.

I propose we can make a similar difference in looking at violence if we can understand the patterns. By starting to look at data and putting things together we can see patterns and those patterns will suggest the ways in which we need to intervene. I don't

think we need sophisticated statistical analysis so much as some very basic detective work. As examples I am going to use suicide and homicide, fatal outcomes of violence, self-directed and interpersonal. Homicide is the second leading cause of death for young people in our country and suicide is the third. Traditionally epidemiological analysis has been looking at patterns that you can see when you pull together data on many people who have something in common. Let's look at suicide statistics: where do they come from and how good are they? Coroners make the determination of whether or not a death is a suicide. If we are going to look at statistical patterns of suicide we have to know that these statistics represent true deaths. How do we know that? Coroners do not have medical training: they are people who run for elective office, who usually want to go on to higher office. The Office of Coroner is one office that is not too highly contested. Medical examiners on the other hand, are usually physicians with some specific training in forensic pathology. A recent poll of medical examiners in this country asked, "What percent of the true suicides do you think that we miss?" According to the response, we miss at least half. The implication is that the suicide rates are actually twice what are reported. We don't lose 28,000 people a year to suicide, we lose more like 60,000 a year to suicide. Who are those missing people? Of those 28,000 reports that we do get, how many are really suicides, and what are the biases that affect the coroner's decisions? Concern for the family's feelings and safety is an important aspect of this decision. Suicides put friends and family members at risk of suicide and current information suggests that there may be such a thing as the contagious spread of suicide. If a coroner calls a teenage death a suicide, then he may be putting other kids in that school or community at risk. This type of pressure is real and widespread; there are numerous reasons not to call the death a suicide.

When we want to look at a pattern, we need to know what we are counting. We need a definition of the case. Who is going to define what suicide is? Spouse abuse: what is going to count as an incident? Are we going to count only injuries? Is it only going to be abuse if the woman comes in battered and beaten with injuries that we can count? This is one area where we need a lot of help and a lot of work, not only for suicide but for all areas of violence.

Let's look at the patterns, bearing in mind that suicide and homicide statistics are not perfect but that their patterns may be helpful. People used to believe that suicide was basically something that older people did. The profile was that of an older white male, often depressed, who had lost his spouse, he might be retired, might have an illness. That was the notion, and interventions were in large part derived from that notion. People looked at statistics and saw nothing there to make them question it. But in the late seventies, a careful look at the statistics revealed a heavy increase of suicide among the young, and in 1980 that rate exceeded all others. Something very important was happening. The next step was to look at the pattern in more detail and break it down by age groups. Looking at the figures from 1950 to 1980, we see that the rates for men and women 65 or older were coming down, while the rates for younger people were skyrocketing. For young men 15 to 19 the rates increased by more than 300 percent during that period. That was missed completely just by looking at the overall rate; you had to look at the pattern a little more closely.

So what are the implications for practice? Looking at the model of the older white male suicide, we see that the stereotypical notion was that he was depressed and that if you treated his depression you would prevent suicide. That may have been an effective prevention technique for those times, but the latest statistics reflect a radical and dramatic change in young people. One recent study in New York suggested that two thirds of the young people who commit suicide are not depressed by any clinical criteria. Therefore, if your intervention strategy and practice are centered around identifying people who are depressed and treating the depression, you are not going to prevent suicide. We need to review the causes, the risk factors, and the prevention strategies. Is depression a cause? Are suicide-prevention centers, hotlines, and other outreach counseling effective prevention strategies? Does it help to let people know that someone cares? Can we do anything in schools to prevent suicide? Can we screen populations for people at high risk and maybe get them into treatment? Should we develop broad-based educational programs? Before we do anything, we need to know what works. Existing programs need to be evaluated; the experts themselves don't know which of these work. The only way that we can find out is by getting the data and looking at the patterns.

Let me focus specifically on homicide among black males. The probability of murder for a white female in our society is 1 out of 450. For a black male it is 1 out of 28. Homicide is the leading cause of death for young black men in our country. The stereotypic notion is that homicide occurs when the victim is out at night in an unfamiliar or undesirable place but the patterns show that most homicides occur among people who know each other. They occur among acquaintances, almost three-quarters involve firearms, and more than half of those involve handguns. We need to look at very different ways to intervene, not just through the criminal justice sector but we need to develop new approaches, because the circumstances of homicide are different from what we rely on the police to stop. Now let's look at multiracial patterns of homicide in crime circumstances for whites, blacks, and others. The patterns prove to be very similar for all races and what that suggests is that people are killed by members of their own race. Therefore, any intervention strategy we develop may be applicable to all people in the high-risk area regardless of race.

One very exciting intervention that has been developed based on the patterns has been the introduction into a school curriculum of a course that teaches students something about the real risk that they face to their health. Dr. Prothrow-Stith's video series that is being shown in the Boston schools makes students very aware of the risks they face from acquaintances when there are guns present and an argument starts and escalates. She teaches them that it is better to be a "coward" for one minute than to be dead. This is an educational intervention based on the patterns. For the project we are looking at, suicide and homicide prevention, the patterns that we see from analyzing data will and must determine the interventions that we use. There is a vital relationship between research and practice, between patterns and intervention, and if we try to separate them into two camps, I think we will ultimately fail to achieve the desired outcome.

Panel Discussion

Regional Data Collection and Analysis

Panel Chairman	Linda Lloyd, M.S.W., Acting Division Director, Environmental Epidemiology, Texas Department of Health, Austin
Panelists	Gregory Istre, M.D., State Epidemiologist, Oklahoma Department of Health
	Suzanne Danilson, M.S.W., Administrator, Maternal and Child Health, Louisiana Office of Preventive and Public Health Service
	Jonathan Sheline, M.D., Medical Epidemiologist, New Mexico Health and Environment Department
	Charles McGrew, M.D.H.A., Director, Arkansas Department of Health Bureau of Public Health Programs
	Ralph Frankowski, Ph.D., Professor of Biometry, School of Public Health, The University of Texas at Austin
Recorder	Ann Gutierrez, Texas Woman's University

Linda Lloyd: This is a unique opportunity for all of us from various states to share with each other our trials and tribulations in data collection, some of our successes, and studies that have been completed. Some of us here submitted a grant proposal last August for a model of a regional data collection and analysis system which will be the topic of tomorrow's meeting.

An unresolved problem in violence data collection and analysis has been lack of a common language. In trying to establish communication among the many agencies who have been working in this area, we are interested in completing a number of tasks: 1) We want to document the problems and determine their magnitude; 2) We want to characterize populations at risk for victimization and for handling stress in an adverse manner; 3) We would like to have an active collection and analysis system capable of identifying emerging problems; 4) We would like a collection and analysis system capable of generating and testing hypotheses. Before we can decide how best to prevent violence in a community, and before we can allocate resources to the prevention of violent death and disability, we need to know which persons or groups are at high risk. We need to know the patterns, the circumstances, the who, what, when and where, and only then can we have some idea of what type of prevention strategies we should be implementing. Data collection and analysis should be viewed as tools that can help us in the process.

Because of the cost in lives, the diminished quality of life, and the number of dollars spent on treating victims, violence is an important public-health problem. We may often use public-health measures to describe the problem, but public health is not the sole owner of violence. It is a community problem that requires a comprehensive approach to its solution.

Dr. Gregory Istre: Although this conference is focused on violence as intentional injury, we must remember that intentional injury is part of a much broader category of all injuries, and when it comes to studying the problem, the distinctions may not be as clear as we usually think. Some motor-vehicle deaths are probably suicides, and alcohol and drug use is a frequent common denominator for all types of injury. While the psychological repercussions may be considerably different, the medical treatment of an injured person is obviously the same whether the injury was intentional, unintentional, self-inflicted, or purposely caused by another person. What is not so obvious is that there may be common methods of preventing intentional and unintentional injuries as well, such as making guns inaccessible, regulating drug and alcohol use, or modifying risk-taking behavior.

In order to identify and evaluate preventive measures for drug and alcohol abuse, risk-taking behavior, and other contributing agents to violence, surveillance for these injuries is essential. This has been classically true with infectious diseases. Surveillance involves collecting data on victims and perpetrators. Some collected data are available at the present time, especially for deaths from injury. We have been able to compare the records of our state medical examiner with those from Vital Statistics, that is the death certificates, for the years 1978 to 1984 in Oklahoma. The medical examiner data contain many pieces of information not included in death certificates, such as autopsy findings and level of blood alcohol as opposed to the time and place of the injury. Of the 18,000 deaths recorded from injuries, premature mortality from injury far surpassed any other category; in fact, the premature mortality from homicide and suicide in our state was greater than that from cancer deaths or that from heart disease.

One of the findings from the review is that the medical examiner data base contained about 20 percent more deaths listed as homicides than did the death certificates, and by contrast the ME data base contained about 20 percent fewer unintentional injury deaths that did the vital records. Our current efforts to determine why discrepancies exist require linking those two data sets, and we are finding problems in analyzing the data. If certain persons are systematically excluded from the data set or misplaced within the data set then enough bias may be present in the study to make the conclusions erroneous. One example from infectious disease epidemiology is that some infectious diseases are reported according to the county of hospitalization rather than the county of residence, and this falsely raises the calculated rate of disease in urban areas where most of the hospitals are.

One other potential difficulty in dealing with data about violence-related injuries is that of confidentiality; in some locales such data may not be available to agencies other than the one that collected it, or interagency sharing of data may be difficult because of confidentiality laws.

Ultimately we will need to evaluate nonfatal instances of violence as well as those which result in death because nonfatal instances outnumber fatal instances probably on the order of 100 to 1. There are currently surveillance systems for nonfatal instances of violence through law enforcement and some other agencies but these still are underreported, and more complete reporting may have to rely upon the development of broad trauma surveillance activities. But in general, despite the potential difficulties in analysis of the currently collected data and despite a relative incompleteness of data about nonfatal violent events, I think that the future is bright for the application of the classic public-health approach to violence prevention. The need is obviously great and the time is right for a collaborative effort which will lead to the prevention of violence.

Suzanne Danilson: This morning I would like to talk about collecting and analyzing data and also tracking data as it relates to child abuse and neglect. Before becoming a health professional I worked in the child protection system in Louisiana for thirteen years, so I hope to offer perspectives both of actually administering child-protection programs and of being an administrator in Maternal and Child Health.

I would like to suggest that we as health professionals have a broad role in child abuse and neglect, much more than just reporting it.. Every state has a child-abuse reporting law in which certain professionals are required to report any suspected cases. Doctors, nurses, social workers, sometimes day-care workers, nutritionists, all have a responsibility to report child abuse and neglect to the mandated agency in their state. It could be argued that our role ends there. Indeed we are not responsible for investigating or proving child abuse and neglect, but we do have some other roles after reporting. We have a role in collecting data within the health department on the number of reported cases. Other roles we have in terms of child health are to improve and maintain the health of the child and family, to reduce infant/child morbidity and mortality, to screen children for health problems.

Child abuse is a complex problem that cannot be adequately handled by one discipline alone. It takes the expertise, experience, and skills of a multidisciplinary team approach. We have all heard of cases of children who have died from injuries or neglect in spite of the fact that they were known to several different agencies. We can never assume that once we have reported child abuse and neglect that it will be handled appropriately. All the agencies need to work together and assume their respective roles in protecting the child.

Our data-collection role should include not only the reporting data but the intervention data as well. It is essential for cooperation that each agency keep clear data. The first essential aspect of our role in reporting child abuse and neglect is to identify it properly. We need to start with a definition. Find out what definition is used by the mandated child-protection agency in your area. If they don't have one, look in the legal statutes in your area for a definition of child abuse, sexual abuse, and neglect. Under each category are different types. With an operational definition of each type and subtype of abuse and neglect, your staff will know what to report, and data-collection will not have so many problems of interpretation. A number of states have already developed sophisticated reporting and tracking systems, notably the CANTS system in Illinois. This system

increased the number of reports, made possible earlier intervention, and resulted in a reduction of child fatalities in Illinois. This sytem has been adapted both in Louisiana and Rhode Island.

Our situation in Louisiana is not too different from that in other parts of the country. Since we began tracking in 1979, child abuse and neglect has increased approximately 27 percent each year. The agency we contract with for our statistics reports a 38 percent substantiation rate. This does not mean that a case was found valid or not. It usually means there was not enough evidence. Case substantiation rates should not be confused with validity rates.

In Louisiana's fatality study on 20 deaths in 1984, we found that 67 percent of the cases in which children died had been known to the health department. In one-third of those cases the children had been receiving regular preventive health care. They all involved children under 4 years old, preschoolers: they all involved physical abuse or neglect. Because in Louisiana we are not yet collecting data on child abuse and neglect, we don't know what happened to these children. I want to leave you with that because I think it has important implications for our role as health-care providers.

Dr. Jonathan Sheline: In New Mexico we have a sizable Hispanic and native American population, native Americans being 8 to 9 percent of the total and Hispanics about 36 percent. We also have several computerized data bases which I think a number of other states also have. Our office investigates all deaths that appear not to be natural.

I think two very important tools in any descriptive epidemiologic research are the ability to download data from mainframe data bases to personal computers and the linking of data bases. I have nearly completed a study on suicide in New Mexico from 1962 through 1984 which was made possible by learning how to download data from the vital statistics mortality files to floppy discs. We looked at vital records from 1962 to 1984 and coded the usual variables, age, sex, ethnicity, and tribe (for native Americans). We looked at three time periods, based on changes in the death certificate form from ICD 7 to 8 to 9. Suicide rates are higher in Western states, so we wanted to determine if ethnicity were a risk factor, the trends in suicide rates by ethnic groups, age, sex and the method of suicide in different ethnic groups. You can see that the sex difference was extremely marked for native Americans and Hispanics and less so for Anglos. We found that patterns of suicide vary substantially among New Mexico's three ethnic groups; we have seen a dramatic increase in suicide by hanging among young native American men and we feel that ethnicity may influence suicide risk in this state.

A study by David Fleming of the Oregon Department of Health linked three data records: the vital records, Office of Medical Investigation records, and the police motor vehicle accident reports. Vital records provide the demographics, the OMI gives you a verbal description of what happened as well as the alcohol level, and the police motor vehicle report gives you the mile marker where the accident actually occurred. Dr. Fleming looked at two causes of death, pedestrian fatality and exposure (freezing to death), which are the two most frequent causes of death for native Americans in New Mexico. The advantage of being able to link in the police report and get the mile marker is that he found

that a lot of these pedestrian hypothermia deaths occur next to off-reservation bars. Phil May from the University of New Mexico has for a long time advocated elimination of prohibition of alcohol on reservations because of the number of deaths near off-reservation bars. This shows you the type of thing that is possible to do when you are able to link data bases. Even though it is descriptive epidemiology, you can still actually get at causation a little bit.

Charles McGrew: I would like to talk briefly about two things that we have been struggling with and that I have heard repeatedly mentioned here. The first is the FBI Uniform Crime Reporting System. There have been many criticisms of the kind of data available and limitations. A study done by APT Associates on the system pointed out the need for more accuracy of data, a greater range of offense types, more detailed information on the nature of the incident, and more analysis and interpretation in the published reports. The study also talked about problems that exist in comparing those data with other criminal data sets.

One of the most exciting things in this area is that right now the Department of Justice and FBI seem to be open to the input of people who are interested in changing the way the data are collected. Major proposed changes from the Department of Justice now include the unit of reporting. Instead of a monthly summary reporting all events, they propose a two-level system of reporting in which everyone would report in level one and then randomly selected cities would support some types of offenses with additional data. States would have the option to have that same data available within the state if they chose to do that. Also it has been suggested that a lot more data be made available to researchers in crime in the United States through publications specifically designed for researchers and that methodology be published in that same series of publications for people interested in how that system can tell us what is going on in our state and in the country. I make an appeal for you to get involved in this revision of the system; as I said before, the FBI and Department of Justice appear to be very open to this, and I think it will be our own fault if we don't see some improvements in the research data available to us in a manner that would allow us to analyze state and local violence data in a more effective way.

The other thing I would like to touch briefly on is what you can do now with the data in educating people who have little idea of the problems we face. Legislators may be aware of the problem but not undersand its magnitude. Trying to interpret the statistics to show legislators how their state ranks with others can be tricky. If you look at the 1985 "Crime in the United States" report for a comparison of areas, you might conclude that Arkansas, for example, falls pretty well below the national average in violent crime; however, at the next level of disaggregation of data where metropolitian statistical areas (MSAs) across the country are compared, Arkansas is shown to be above the national average in murders and rapes. Therefore, the first thing that you are going to have to do with a lot of people whom you talk to about the issue is to get past some of the superficial assurances that state data comparisons may give.

One thing we need to research very carefully is handgun control. Most of the people in our regions, especially rural populations, have very strong feelings about the right to

bear arms. We in this room all have feelings about what would happen if we made handguns unavailable, but we don't have conclusive data. If we don't provide good, accurate data on the issue, I think we will be making a grave error. The National Rifle Association has very good folks looking at the data, comparing studies done, and getting that data back out to communities to support the citizenry's being able to maintain those guns. I think we ought to move forward as rapidly as we can with getting good data, but at the same time be cautious in our own conclusions that are published about the impact of handguns right now.

Dr. Ralph Frankowski: The original title proposed for this session was "Surveillance of Injuries." There were objections that this sounded a little intimidating, so it was changed to "Regional Data Collection and Analysis." I would like to point out that routine data collection and analysis is not synonymous with surveillance; the two are very different.

We have accepted this notion of surveillance as a national recommendation, and I think perhaps we sometimes accept things a bit uncritically. Let me give a little background on surveillance. Going back to the French work *surveillance,* which was adopted about the time of the Napoleonic wars, it was used by the English to signify keeping a close watch over an individual or group in order to detect subversive tendencies. Current dictionary definition defines it as a watch or guard over a suspected person. How do we use it in public health? Originally it was the process that led to quarantine. In 1878 Congress passed an act for the collection of morbidity reports against the dreaded diseases yellow fever, smallpox, and cholera. This was the beginning of disease surveillance, and over the years diseases were added to the list. But until 1950 surveillance was essentially restricted to watching contacts of serious diseases with a very specific, important but narrow purpose of detecting first symptoms so that treatment and isolation could be initiated. In 1950 the term surveillance was removed from its bond with individuals and placed in the context of disease. That is, the object of surveillance became the disease itself. The methodology changed dramatically then and surveillance is now really three things: 1) a systematic collection of relevant data, 2) constant evaluation, and 3) the prompt dissemination to all who need to know.

I think one point we need to address in the whole matter of surveillance is responsible alertness and appropriate action on indication, because in my mind, surveillance is predicated on an assumption that with well-informed officials supported by an informed and understanding public, corrective actions will be taken and for the most part are taken. You have heard of some of the problems we have with surveillance and the continuous monitoring of data. We need good data quality, but we do not need 100 percent reporting. Rather than the quantity of information, we should emphasize the type of information we need. It is not likely to be found in these big records systems that we are all trying to merge. What we need in injuries is the same thing we needed two hundred years ago for infectious disease; relevant pre-event, event, and post-event information. The events surrounding the injury are as important as, if not more important than, the injury itself. The vital statistics system is wonderful: it will point to a problem area; you can find regional variations of mortality; we can subgroup mortality age, gender, and ethnicity; we

can identify patterns. But for surveillance, that is not enough. It will only point the way to the most severe part of the problem. Where else can we find information? Law enforcement agencies are a depressingly abundant source of that information. The new Uniform Crime Act is going to be a very major effort in this whole area of intervention. Agencies need to get together as soon as possible to talk about the common goals that we have, the control and prevention of injury. Health authorities--workers in the field, people who can do evaluation, people who can do patterns--rarely talk to each other.

Hospitals have a lot of information; I think hospital data has real potential for surveillance, but one critical item is missing. We know why people are hospitalized, we know about the injuries that were treated, but the hospitals very rarely if ever record what we call external causes: what caused, and what were the circumstances of the injury? A second gap in hospital information is that there is usually no uniform recording of emergency-room admissions.

Lastly, population-based surveillance is probably the most difficult task of all. I think a distant glimmer of hope can be found in the health-maintenance organizations that are working with defined populations, well known and under a constant microscope of medical service utilization.

I am concerned that we are separating intentional from unintentional injury. Dr. Rosenberg used the example of polio and the swimming hole. If we only look at the notion of spinal cord injury from the intentional point of view, we would not perhaps find out in a surveillance system that the swimming hole is the cause of the spinal cord injury.

We talked about the quality of data. This is extraordinarily important, but it can be paralyzingly important, and we have to be careful of that. There is one other aspect that we need to pay attention to. The value of surveillance increases with the quality of data but the understanding by health authorities and politicians of the information provided requires education, patience, and presentation in an intelligible and useful manner. The challenge in surveillance is not only to collect and collate but to present the data to the politicians, to our officials, to our people so as to achieve effective action and then to evaluate the effects of that intervention.

Linda Lloyd: We propose a regional surveillance and monitoring system that would include the five states with their unique geographical differences. There would be ways within this proposal to allow for the uniqueness of each state but at the same time to effect standardization which would enable us to use this model for other regions of the country.

In defining surveillance and monitoring, we decided to use a World Health Organization definition which very simply states "an integrated system of making observations." Health surveillance is the closely associated system of collating and interpreting data collected from monitoring programs and from any other relevant sources.

People who are reviewing proposals look for clearly stated goals, objectives, and purposes. Our proposal is not as concrete as it might be; when you are talking about five states it is hard to get concrete. We wanted to remain flexible. Our purpose was to establish a system of monitoring and surveillance that would identify and access data sources, analyze mortality data, and disseminate the results to organizations and agencies. So we are

moving beyond actual data collection and analysis and into dissemination, realizing that dissemination is an integral part of any type of data-collection system.

We visualize a regional network in which communication of the sort that is occurring at this conference would be important. We thought that in view of our limited health-care dollars, it was important to share information and experiences. We also thought it was important to get on with a reliable data base before attempting to make any decisions for the future. Before we talk about intervention, we need to know what is happening; and this is what we are hoping to accomplish with our monitoring, surveillance, and dissemination system.

We have identified four health problems in connection with violence. The two nonfatal areas that the Centers for Disease Control are interested in are child abuse and rape. We know that four of the five states in this region consistently have a forcible rape rate higher than the national rate. The two fatal areas we are dealing with are homicide and suicide.

We propose two levels of operation: a regional coordinating center located at the Texas Department of Health in the Bureau of Epidemiology and an epidemiologist working in each of the state health departments. At a regional level we are going to use vital statistics data and determine with respect to selected demographic characteristics the incidence in ten-year trends of fatal intentional injuries within the five-state area. We are also interested in the quality and usefulness of fatal intentional injury data on the existing vital-statistics reporting systems. The vital statistics are unique in their scope, and on the state level they are unique in the fact that we do have a rapid turnaround, whereas at the federal level this may not be the case. But we have unique problems too. In Texas the majority of our vital statistics records are completed by county judges. County judges have interesting opinions on why somebody dies. We need to assess their systems for strengths and weaknesses. This is another activity that will be taking place at the regional level.

In terms of vital statistics, we are basically going to do what the Centers for Disease Control did on homicide and suicide. We are also going to prepare a report, and by interviewing, discussion, and review of reports determine the strengths and limitations of the current vital statistics systems. To help us evaluate these systems, we are planning to put together a panel of regional and national experts which will come up with recommendations for the region as a whole as well as more long-term recommendations for the vital statistics systems in the country. We expect the proposed project to be able to interface with universities and public-health departments.

Marketing of information regarding violence is very important, and I think we can use the 1990 health objectives that are part of our proposal to help us in this. Our 1990 health objectives are intended to embarrass people. We are saying to them: "This is the present situation; here is our goal for changing it; what are you going to do about it?" For the first time we have something that is measurable. We found that the national level 1990 health objectives didn't focus on the 15-to-35 age group homicide or on Hispanic homicide, so we created our own regional objectives in these areas.

So, the regional office will act as a resource for state level offices and will be involved in mortality analysis. At the state level, the first and primary concern will be a

comprehensive inventory of existing channels of information. The whole project understands that other agencies are and have been collecting information. It is sometimes suggested that we need to develop something new that will integrate all of this. Before we develop a comprehensive surveillance system, we need to know what is there. We are going to have a systematic standardized format for each state, analyzing and assessing their information.

As we go around the region interviewing people, attending community groups, and getting other people involved, we expect to widen our opportunities for collaborative effort. It is important for us to identify "key informants" whom we can consult with about area problems--county judges, state legislators, public-health professionals. Why do *they* think that violence is not a serious enough problem to spark community-level interventions?

We plan a system in which there will be standard procedures across the five-state area that will enable us to make comparisons. Should New Mexico decide to do something in rape crisis and Oklahoma decide to do something in spouse abuse, we would be able to have a standardized format for analyzing these data even though the sources were different.

A quick outline of state-level responsibilities: 1) we need to have the data before we can analyze it; 2) we need to identify key informants and inventory resources for each state; 3) we need to prepare a data/text file so that we will have a permanent record of what is being collected and the usefulness of that information.

Symposium

The Costs of Violence and Its Impact upon Future Legislation

Moderator	Eddie Bernice Johnson, Senator, State of Texas, Austin
Panelists	Diane Ragsdale, Mayor Pro Tem of Dallas
	Louis A. DeNino, Ph.D., Assistant Professor of Economics in Human Ecology and Community Health Practice, University of Texas Health Science Center at Houston
	Catalina Esperanza Garcia, M.D., Anesthesiologist, Dallas
	Daniel W. Shuman, J.D., Professor of Law, Southern Methodist University, Dallas
Consultant	Mark Rosenberg, M.D., M.P.P., Chief of Violence Epidemiology Branch, Centers for Disease Control, Atlanta

Diane Ragsdale: Let's talk about Dallas, Texas, where I serve on the city council. During the ten-year period of 1976-1985 the number of index crimes in Dallas rose from 91,280 to 129,000, an increase of 41.9 percent. Violent crime, murder, rape, robbery, and aggravated assault increased by 98.3 percent, while property crime increased by 37 percent during the same time period. Specifically, murder increased by 30.9 percent, rape and robbery by 94.4 percent, aggravated assault by 107.3 percent, and burglary by 37.2 percent. In comparison with other major cities, Dallas has historically been near the top in total indexed crime per one thousand population. Although the population in Dallas increased by only 10.7 percent during this time, the number of requests for police service increased by 52.7 percent. In 1985, of the top 33 cities in the United States, Dallas ranked number 4 in murder, number 6 in rape, number 16 in robbery, number 11 in aggravated assault, and number 1 in police shooting. Looking at the City of Dallas budget, from 1981 to 1987, we find that in 1981 to 1982 the police budget was $85 million while the city Health and Human Services budget was $8 million. In 1986-87 the police budget was $136,221,000 and the Health and Human Services budget was $12.8 million. We see a clear difference in emphasis between elements of crime control and elements of crime prevention.

According to the Mayor's Criminal Justice Task Force Report, studies have shown that the cost of crime averaged $2,000 per inmate. The chronic recidivist, or the repeat offender, committed an estimated 61 percent of all crimes. If we look at the chronic repeat offenders we will find overall that Dallas County spent or lost over $155 million to

recidivism. We citizens of Dallas County could have saved this $155 million lost to recidivism if we had spent more money on education, drug and alcohol-abuse prevention and treatment programs, as well as other crime-prevention programs. At the Texas Department of Corrections (TDC), the average inmate cost in 1985 equaled $7,763. A repeat offender's average annual cost to society equals approximately $38,000. Furthermore, according to the Mayor's Criminal Justice Task Force Report, a vast majority of TDC inmates are functionally illiterate; 13 inmates out of 36,000 graduated from high school. Also 2 out of 5 inmates were under the influence of drugs or were drunk at the time of their offense. The McAlister Act, passed in the late seventies, calls for drug and alcohol prevention and treatment programs but has never been sufficiently funded. Texas spends less per capita than any other state in the nation on alcohol and drug abuse prevention and treatment programs and ranks 29th in the nation on dollars spent per student for education.

I guess the issue is that we seem not to adhere to and emphasize the old truism that an ounce of prevention is worth a pound of cure. I hope that from this conference both those in attendance and elected officials will learn there is a need to pull together the necessary resources to establish a comprehensive plan which minimizes crime and, therefore, the cost to the taxpayers. We must begin to look at the underlying causes.

Dr. Louis DeNino: We all know that violence generates considerable costs to society. Ms. Ragsdale gave you an idea of what an important part it is of the city budget of Dallas. Many of the costs are borne directly by taxpayers. We are aware of criminal justice costs, prison costs, and monetary assistance to victims in the form of disability checks and increased welfare expenses. What we often fail to recognize is that the medical costs of violence are also in large part borne by taxpayers as well as victims. Public hospitals see a disproportionate share of violence victims, many of whom are medically indigent. In addition public outpatient clinics, rehabilitation homes, health, counseling, and other programs render services to victims and their families.

The research that I'm going to present here today is the result of a pilot study aimed at estimating the medical costs of violence absorbed by a public hospital. This research represents a small first step towards estimating the total medical costs of violence borne by taxpayers. Certainly knowledge of these costs is useful from the perspectives not only of legislative action and program development to reduce violence but also for planning on the part of institutions which currently deliver medical services to victims. Cost-of-illness methodology initiated in 1966 by Dorothy Rice attempts to measure the total cost over the lifetime of anyone who is suffering from a particular illness such as coronary heart disease, forms of cancer, etc. In 1976 Cooper and Rice updated and perfected the methodology, and this is the methodology that we adopt to estimate the medical cost of violence. Hospital charges are adjusted to costs by using a cost-to-charge ratio, which is estimated in our study on the basis of services delivered to a subset of the sample in each of the three main categories--gunshot wounds, stabbings, and aggravated assault.

We are using the prevalence approach to the problem, in which we look at all the victims of a particular disease or injury in a particular year and see how much it costs to treat those patients over that year, and this gives us the health costs. We believe that the

results of such a study will be useful to determine whether or not preventive programs are cost-effective. If we lower the amount of violence in society, how much will the total savings be in terms of medical expenses?

There are two types of costs to be borne. The category of direct costs comprises goods and services actually utilized in the medical treatment of the disease or injury in question and includes expenses for emergency services, hospitalization and outpatient treatment, drugs and medical supplies, medical equipment and appliances, home modifications, paramedical expenses, institutional care, and rehabilitation services. Direct costs also include the administrative expenses of managing and funding the medical care. The indirect costs of any disease, including intentional injury, are the goods and services not produced due to physical impairment of victims. Frequently we also distinguish between morbidity costs, which are indirect costs arising when people are too ill to work, and mortality costs, which measure the lowered economic product due to death. The data concerning the direct costs of injury due to violence are not generally available across the United States today. A 1984 Department of Justice study that discussed medical costs attributed to violent acts asked victims questions like, "What was the size of your total medical bill?" The responses to such a question cannot be very reliable since they don't specify, for example, costs outside of the hospital, any drugs, counseling, and so forth. Also, they fail to differentiate between costs and charges. Charges include the costs plus some markup and we're mainly interested in what the cost is in terms of resources to society.

[Dr. DeNino described his study, which is covered in his paper, "Medical Costs of Violence to Taxpayers in Harris County, Texas: Pilot Study," included in appendix C of this volume.]

What can we conclude from one month's data at a county hospital? The pilot study demonstrates first of all that it is possible to use hospital records to estimate the in-hospital costs of violence. The data for July 1986 indicate that most victims are male, with women more inclined to have injuries due to aggravated assault and abuse. The in-hospital costs of the majority of individual patients are well below $1,000 apiece, with most being below $500. This indicates that the total cost is heavily influenced by a small number of serious cases. Thus the costs of violent injury are volatile from one time period to another, as severity can fluctuate over time. For this reason we wish that we could have adjusted our findings to incorporate seasonality factors. We believe the results presented are representative of the magnitude of hospital costs associated with violent injuries at one public hospital. A cost of over $6,000,000 at one county hospital is considerable. We would speculate that most of these costs are borne by taxpayers since violent injury tends to be overrepresented in low-income and uninsured populations. When we consider that these are only in-hospital costs at one hospital and do not include the cost of outpatient rehabilitation and counseling services we feel secure in hypothesizing total medical costs of violence in Harris County to be in the tens of millions of dollars and that a large part of these costs are borne directly by taxpayers.

Dr. Catalina Garcia: I'm an Anesthesiologist by trade. My introduction to violence in Dallas was through my medical experience. When friends of mine went off to fight in Vietnam, I thought "they are going to learn so much and handle acute situations I'll never have to handle." But when they came back I found that every case my friends described to me had been duplicated with victims in Dallas County. This is a very violent society. Yes, that was in a city-county hospital, but if you check the records of emergency rooms in private hospitals there is a lot of trauma. Of patients with psychiatric illnesses that require hospitalization, half give a history of family violence. I'm on the board at Family Place and through them I have learned a great deal about the family abuse situation of Dallas. Who is the victim? Patients who can afford private medical care and don't have to discuss it, do not discuss it. About one-fourth of the cases that come into emergency rooms are trauma related. Does that mean that all the other emergency cases are in no way related to any sort of abuse? The patient is not questioned in that way and so nobody knows.

Why is domestic violence so important? Because the lost years are so much greater. The primary cause of death in the younger age groups is accidents. Some of these are violent accidents, and some are in the home. When you start counting up the number of people-years lost, it becomes obvious how important violence is in the loss of our population. A study conducted by investigators at Case Western Reserve University in Cleveland found four times more cases of assault in hospital records than in police reports, so a lot of reports are not making it to the police department.

Domestic violence is epidemic in our country right now and if we stop and think about the infectious diseases that have succumbed to medical science, we see that many years before there were immunizations or antibiotics people had already started figuring out some of the sociological causes of these diseases, for example, overcrowding, malnutrition, and unclean water. The changes in infectious disease incidence were already initiated even before the medical discoveries. So I think that we need to attack this as we would any other disease. When I first went to a conference and heard a discussion of family violence, I thought, "I'm in private practice, I never see things like that." But then I started asking some of my patients how they got some of the injuries that they had, and I was aghast to find out that family violence was involved. Domestic violence does not have marketing appeal and it doesn't really have reimbursement incentives. So how are we going to get people to face this as a problem that needs to be addressed? I really don't have the answers.

To finish, I'd like to give you an idea of the cost of one case of family abuse in Dallas. A protective order costs $16, the minimum court time is two sessions per case, times 2 people (the victim and abuser). You've got $1,600 now. The cost of a police call is $9. The loss of workdays: at least 2 days in court plus sick time--that's $3.35 an hour times 8 hours times 2 days times 2 people-- that's $107. If a child must be absent from school, how do you compute the cost of what the child did not learn that day? Twenty four percent of battered women require medical treatment; the emergency-room visit is $47, a clinic visit is $27. If she is admitted to the hospital and takes a semi-private room, it's $230. Damage to property is estimated at $100 per day per person in the United States, so

we'll put in $100. A shelter may have to house this mother and children at $20 a day for maybe 30 days; that's $600. AFDC for a mother and three children for 30 days costs $271. Food stamps another $221. So you're looking at nearly $4,000 per case.

Daniel Shuman: I want to talk about some of the systemic costs of violence in the context of the legal system. Violence in our society is a problem that sickens even the strongest of heart and calls for a strong response by even the most timid among us. Our repulsion to this violence is magnified many times over when the violence is committed by adults against children. Therefore when out of the chaos of this violence there emerges a sage carrying a crystal ball who says that in the ball can be seen the identities of individuals who have abused children, we let out a sigh of relief; the children have been saved. But prosecuting instances of child abuse presents difficult problems from a legal perspective. Generally, instances of child abuse involve only the abusing adult and the abused child. This makes difficult problems because of the identity of the abuser and the fact that this is an instance of abuse rather than an accidental injury. In addition, the child may be physically incapable of testifying because of infancy or because of the consequences of the abuse itself. Even if the child is physically capable of testifying, legal rules may provide that the child is not old enough to give testimony. Even if the child is old enough to give testimony, we may be suspicious of that testimony because of a belief that it is a product of childhood fantasies. Even when there is a witness to these acts of abuse, it is typically the other parent and that individual is also frequently suspect. Parents in custody battles have recently begun to fling allegations of child abuse at each other, and family lawyers tell you they are convinced in large measure that most of these are attempts to stave off custody battles, in fact, that there is reason to question the credibility of many of these allegations. In light of these problems of proof, and the horror of child abuse, we have resorted to our experts with crystal balls--individuals who claim to be able to determine on the basis of a cluster of traits or characteristics common in parents known to abuse children that a particular individual is likely to be a child abuser. The experts who testify in this capacity vary from medical doctors to social service workers. The litany of characteristics they cite varies, but in the main these tend to include low self-esteem, poor impulse control, low empathy, low frustration tolerance, inadequate child-development knowledge and parenting skills, and a history of having been abused as children. Based on the defendant's conformance to these characteristics the jury is then asked to conclude that this individual is likely to be the sort of person who abuses children and is therefore likely to have abused this child in this particular case.

My concern is with the clarity of the experts' crystal ball. Is it well grounded scientifically and is it being accurately presented in court? What does the research reveal? The first thing that the research reveals is that in the diagnostic and statistical manual of the American Psychiatric Association there is no such thing as a battering parent syndrome. Therefore the extent to which this is useful is the extent to which the research itself supports this conclusion. What then, does the actual research reveal? The research is not largely what one would call scientific; it is a collection of clinical or anecdotal episodes that individuals who have treated abused children see in the parents who have abused these

children. In those instances where there are well controlled scientific studies, they tend to involve a study of mothers who abuse children. However, the majority of defendants in court cases are fathers, and therefore from a scientific perspective the extent to which one can generalize from research about women who abuse children to men who abuse children is problematic. Looking at the specific studies is even more disturbing because findings are inconsistent. Some studies conclude that abusing mothers are younger than nonabusing mothers and come from lower socioeconomic groups. Other studies find that there is no difference in age or socioeconomic group between abusing mothers and normal population. Some studies conclude that the abusers have a higher incidence of psychiatric disorders, others conclude there's no difference in the incidence of psychiatric disorders in this group from that of the normal population. Some conclude that abusing mothers have lower intelligence as compared with the normal population. The research also suggests that there is probably not a reliable test or diagnostic tool, and if such a thing as a battering parent syndrome exists, not one, but at least four or five different syndromes apply.

A test or diagnostic tool which attempts to identify child abusers must be measured by its sensitivity and specificity. Sensitivity in this particular case is the ability to identify most child abusers, specificity is the ability not to erroneously label as an abuser someone who is not an abuser. An error in sensitivity is called a false negative and an error in specificity is called a false positive. The best study that I was able to find was a predictive study at Vanderbilt University Hospital. The study surveyed 1,400 pregnant women who were about to give birth, in an attempt to use criteria identified from previous studies of abusive mothers to make predictions of future child-abusers. Using a fairly structured interview, they identified 200 women who might be expected to abuse their children. Two years later they searched the central registry in Tennessee that would include all reported cases of child abuse. They found that of the 200, 2 percent of all the mothers in the total population of 1,400, had abused their children. Of the 273 they had predicted were going to abuse, 6 percent had had reports filed. Which means that in 94 percent of the cases there was an erroneous prediction that these individuals were going to abuse. If you had made a prediction that no parent was going to abuse, you would be right because of the low base rate in 98 percent of the cases. Any time you made a prediction that someone *was* going to abuse based on these criteria you would be wrong in 94 percent of the cases and right in 6 percent of the cases. Those are the false positives, all the people who would be erroneously labeled as child abusers according to these criteria. The other question is the false negative: did it catch all the people in the population who are child abusers? There were 30 child abusers: half were found in the population that had been identified as likely to abuse and half were found in the population not expected to abuse. According to the logic used in conceiving this study a defense lawyer might take a client on the witness stand who is charged with abuse but who doesn't look like an abuser (according to these criteria) and say to the jury through an expert "this person doesn't look like a child abuser, therefore this person isn't a child abuser." According to this research half of the people who abused children don't look like what we expected child abusers to look like.

The objective of this particular research study I'm talking about was simply to permit identification of these women so that timely assistance could be given to them before there was an instance of child abuse. In that context it may be reasonable to have this degree of false positives and false negatives present. But in the judicial context we are either taking someone's child away from them or putting somebody in jail, and therefore we need a higher accuracy rate. I don't think even the researchers would suggest that this kind of research is appropriate to use in the judicial context. Now this is a difficult problem and it's unlikely from what my researcher friends tell me that a highly accurate test can be formulated to predict an event that occurs with as low a base rate as 2 percent. To use bad scientific research or scientific research that was never designed to be used in the judicial context, to salve our collective conscience that we have adequately addressed the problems of child abuse does not do so.

PART VII

◊ **Summaries of Workshops and Symposia**

Summaries of Workshops and Symposia

This section of the conference provided a summary of each of the workshops and symposia by the recorders assigned to the events. Each meeting was also recorded on audio tape by Berg Recording Specialists, 3 Dallas Communications Complex, Irving, Texas 75039-3510. These tapes are presently available, but it must be noted that they vary greatly in quality, and a couple are virtually inaudible.

The following summaries also vary greatly, in length, form, and the type of information gleaned by the individual recorder. We present them pretty much as they were submitted, except for overlong summaries which it was necessary to cut. Sessions for which no summary was available were summarized by the editor based on the transcripts. Some summaries contain information that was not included in the transcripts due to our space limitations, and anyone interested in a given presentation is urged to consult both the summary and the transcript for maximum benefit.

Symposium: Violence as a Special Health Problem for Minorities

Recorder: Wekota Crowghost

Dr. Everett Rhoades, Moderator: Certain conditions are unevenly distributed in the general population. Six major problems, which include 1) cancer, cardiac distress, and stroke, 2) diabetes, 3) homicide, 4) accidents, and 5) infant mortality, occur more widely in minority populations.

Dr. Fernando Guerra: Some of the data are lacking because of the reporting systems for identifying violence and neglect in families. Many of the child accidental injuries were in and along the Mexico border. A fourteen-year old boy was beaten by his peers because of a young girl. The young man was down, but the others continued to beat him. The young man, like many of the young males observed by the speaker, did not understand the skills to negotiate.

If medical professionals would ask individuals what is going on at home, they could better detect individuals' special needs. Social-service nurses, doctors, and secretaries frequently interact with victims and in speaking with them could see where abuse is happening. The health-care system can be a more responsible system. Leisure time is important to families staying healthy. Interacting with other disciplines such as the education and justice system is important in this aspect. A better way of life can be imparted to children before they leave home.

Joseph Little: Violence in the Indian community has been with us since the beginning of our country. Young Indian men are killing themselves. Many cases seen are child neglect and self-inflicted injury related to alcohol abuse. In most of these cases, the communities are tightly knit, and everyone tends to know what is going on. A tribe is a sovereign government, and tribes are different from each other. Some have jails on the reservation,

others use state jails and pay for the use of them. In a child-abuse case, you cannot always take the children because of state jurisdiction or federal jurisdiction. All Indian Health Service, Bureau of Indian Affairs and Social Service tribal services and BIA police should work together to share information and keep accurate records. Presently, very few of these groups are working together as a unit. Some of the local communities are trying to coordinate and help the people in these abuse situations, as in New Mexico.

When a child is abused, the officials should know. Protection services are available to Indian children through on-reservation schools and other schools, but many of these services are underused.

Ron Cowart: The cycle of violence is different for refugees in East Dallas's "Little Asia." Many have seen their parents, brothers, relatives, friends killed in war. There is a high cultural distinction among Asians and racial purity is important. A refugee can never go back. Many of the people in "Little Asia" have different languages, cultures, religion, etc., and we need to learn to deal with them.

Frustration, anger, and poverty most affect the black community. There is a cycle of violence that overwhelms the black community. Blacks have been affected with violence since slavery. In 1960 and 1963 homicide rates were high. In 1980 homicide rates appeared to be going down but may be on the increase again. Forty percent of black homicides are committed in the South. Firearms as homicide weapons decreased from 1976 to 1983. Many victims know their assailants. The profile of the black victim is male, 30 years old, living in a large urban area, and killed by a handgun. The profile of black female victims is similar, except that they are usually killed by their husband or boyfriend. Perpetrators have a low educational level. Substance abuse is a large factor. The increase in rape and substance abuse may be a new outlet for the black population to help explain the drop in the homicide rate.

Workshop: Child Sexual Abuse

Recorder: Pam Ruthven

[Presentation and summary of state-of-the-art research and discussion of available data.]

The purpose of this workshop was to explore the status of child sexual abuse in terms of research, data systems, and treatment and to determine what needs to be done to communicate the issues involved in this area.

Incidence: Recent reports indicate that for every reported case of child sexual abuse there are approximately five unreported. For every eight seen in the emergency room or for every four written up in hospital discharge notes, only one gets reported. One of the main reasons for this discrepancy is a lack of a standardized definition of this abuse, making it difficult to compare research studies.

Issues in Research Methodology: Recommendations were made for standardized and improved research procedures so as to gain more information about the problem. Poorly designed and executed studies have limited the comparison of results. In the past, most studies were retrospective, telling us about what happened 20 years ago. Today, national surveys of adolescents are needed to tell us what has happened in recent years. It was noted that the family has changed dramatically since the seventies and more current information is needed with regard to prevalence and patterns of the problem. Good prospective, retrospective, longitudinal, and follow-up studies are needed. However, these are often difficult to do as the families involved are often chaotic and tend to move many times. Barriers to good data collection include lack of control groups, overreporting for certain ethnic/economic groups, weaknesses inherent in broad-based and direct questions, resistance in respondents, lumping together of victims (genital contact or not) and perpetrators (recalcitrant and one-time offenders), lack of knowledge of normal and abnormal sexual behavior in children, lack of establishment of norms and training in the use of anatomically correct dolls, and the poor training of professionals in identification of abuse. Included in this was the question of who should be responsible for the collection of data. It was also noted that agencies collecting data often have their own goals regarding the data and that each state has its own definition thereby creating vast differences in each state.

In light of the above findings, it is also necessary to establish statistical standards of analysis for child sexual abuse data. The largest failing in research is the use of correlation analysis to determine a cause-effect relationship.

Factors Involved in Child Sexual Abuse: We know much more about children who have severe problems then about those who do cope better. Factors which affect outcomes include response of parents, peers, and professionals and child's psychological, biological, and developmental level of functioning. We know that child sexual abuse is a traumatic experience leading to anxiety, fears, hyperalertness, guilt, depression, somatic complaints, stigmatization and low self-esteem, sleep disturbance and nightmares, behavioral problems at home and school, increased sexual activity, adolescent truancy and promiscuity. Recent studies have suggested that factors which most reliably predict behavioral problems in children are abuse by a powerful male adult, genital contact with use of force, and lack of family support (emotionally distant mother). It was recommended that increased support for the child along with ways to generate empowerment will do much to improve the outcome. Our response to the abuse might be as important (if not more important than) the victimization for the final outcome.

[Discussion summary and suggestions for future actions involving data collection.]

Factors Affecting Outcome: Despite great increases in knowledge about sexual abuse in recent years, we still have considerable gaps in our understanding of sexual victimization. We know that, as with other traumatic events, some children cope better than others and in fact roughly one-third of sexually abused children have healthy long-term outcomes.

Previous studies have looked at the behavioral/emotional consequences for children on either a short- or long-term basis. However, we do not know the relationship between short-and long-term outcomes. A child may develop an adaptive pattern for a positive short-term outcome, e.g., disassociation, which would not serve him/her in the long term in terms of adult relationships. The question is: do positive short-term outcomes predict positive long term-outcomes or do positive short-term outcomes predict negative long-term outcomes? It was suggested that the latter is most likely true.

It was recognized that among the many factors influencing the outcome for the child are the child's ability to cope with stress and to adapt, environmental factors such as agency and court response, family factors such as the response of siblings, peers, and parents to the disclosure, and the developmental level and context of the child.

It was noted that if the victimization occurred over several developmental stages for the child that it would have a greater long-term effect. Thus, it would be important to attend to the child's needs over several subsequent developmental stages in order to increase the likelihood of a more positive outcome.

In light of these issues it was recommended that both short- and long-term treatment need to be considered for the child. This treatment should seek to provide the child with a sense of mastery over his or her world, some level of control with friends, school; to help the child regain a sense of self after what is likely to have been a self-damaging situation; and to develop ways for the child to experience some level of control over his environment, e.g., scheduling of appointments, writing a letter to the perpetrator, and an opportunity to understand the trauma through a group experience with other children of similar age, sex, and situation.

Future Research and Endeavors: Several recommendations from the workshop:

- A medical and legal definition of child sexual abuse.
- An improvement in regional prevalence studies with the suggestion of doing a simultaneous standardized national survey of adolescents to assess what has been happening to victims in recent years.
- A greater understanding of normal individual and family sexual development, as it is essential to know what is normal in order to understand what is abnormal. Included in this is the validation of many of the instruments and techniques currently used to identify abuse.
- A need to identify long-term effects for the different developmental ages of the victims. Understanding these factors will enable us better to plan therapeutic interventions.
- A need for greater cooperation between the medical, psychological, social, legal, and psychiatric services so as to improve the quality of data collection, court testimony and treatment. It was recommended that a written contract be established between these local agencies for this purpose.
- The establishment of a centrally located state recording system in each state to standardize data collection. Each state should take the time to see what has worked or failed in other states as they establish their own system.

- Increased professional training so as to aid in the identification, verification and treatment of the sexual abuse victim. This training might include public-health training teams going into isolated areas to educate physicians and law-enforcement personnel.
- Multidisciplinary teams formed to deal with cases of sexual abuse in each county area, available as needed. These would ensure standardization on many levels as well as providing more reliable information to be used in court. Included on these teams should be physicians, psychiatrists, other public-health professionals, psychologists, lawyers, and social workers. This team approach would provide support in decisionmaking for the professionals regarding sexual-abuse cases as well as providing a unified and hopefully streamlined approach to the investigation of the reported abuse.
- Assessment of various risk factors which seem to predispose some children to sexual abuse, contributing to our knowledge about establishing an effective prevention program.
- An increase in family-life education in the schools and parenting centers so as to increase awareness and to improve the functioning of the family overall.
- An overall sense of cooperation by all states in the region in terms of funding and resources and the use of local rape crisis centers for state-of-the-art information.

It was noted that there needed to be an increase in awareness of how states could procure funding to assist in the areas. Rape prevention and social-service block grants are able to allocate funds for sexual abuse. It will take coordination of service providers on the local level to investigate various funding resources available to them.

Despite the great amount we know about child sexual abuse as compared to ten years ago, there still is a great deal that we do not understand or know how best to treat. It was recommended that we return to a search for basic answers, not for the purpose of differentiating treatment needs, but for a better understanding of what we are dealing with. Moreover, in all that is attempted, a primary focus on the separate treatment needs of each client was considered essential.

Workshop: Child Abuse

Recorder: Denise Clemons

Child abuse is an epidemic public-health problem. We need to look at all causes of this problem. Alcohol is an important risk factor in child abuse. Children growing up in alcoholic homes and abusive homes display very similar behavior, e.g., secretiveness, isolation, some maladjustive behavior.

I. In the area of diagnosis and intervention in abusive families:
   A. Only in the last two decades has the approach to child abuse become realistic.
   B. Practice of professionals may be impaired by personal prejudices, values and feelings; clinicians must contend with their own feelings regarding abuse of children and understand how these feelings may impact on their actions.
   C. Too often, race, ethnicity, and class dictate which cases are reported.

II. In the area of prevention, the following points were made.
   A. Abusive families are low in cohesion, supportiveness, encouragement of independence, and achievement of goals. Abusive families are high in conflict, anger, aggressiveness, and control. In development of prevention programs, there is a need to address these variables.
   B. Parental-support programs for new parents can make significant differences. Control studies show significant differences in the rates of child abuse between parents involved in primary prevention programs and parents without intervention.
      1. Lay-health visitor programs encourage a family with a new baby to request the ongoing assistance of a successful parent who is trained to give referrals as well as support.
      2. Discussion groups help to reduce the isolation that is an important aspect of the abuse syndrome.
   C. All prevention/intervention programs need to have a self-evaluation component. We don't know what works yet.
   D. We are a society fascinated with violence. We have attitudinal problems that must be recognized and addressed.
      1. Freud's theory of infant sexuality was a "cop-out" in response to widespread disapproval of his earlier theory on early abuse as a cause of adult hysteria in females.
      2. Much advertising in American uses children to create sexual appeal, and many cartoons, bumper stickers, etc. make fun of family violence. Sex and violence are often linked in the media as well as in pornography.
      3. The issue of corporal punishment for children must be debated openly.

III. Alcohol abuse and its relationship to child abuse
   A. The prevalence rates of alcohol involvement in family violence incidents are underestimated. Reports are limited by differing reporting techniques and methods of evaluation of various agencies.
   B. There is no centralized data system to effectively determine whether different agencies are working with the same family.
   C. Alcoholism is an important risk factor in the severity of child abuse. The more a parent drinks, the more severe the abuse.
   D. There are significant similarities in the maladaptive behaviors of children growing up in alcoholic homes and children growing up in abusive homes.

IV. Five recommendations emerged from the workshop
   A. Standardize methods used for correlating child abuse to alcohol abuse.
   B. Create a central data system to more effectively link prevalence of alcohol to child abuse.
   C. Increase communication between agencies.
   D. Find out what effect the parent support programs have on the variables noted in abusive families.
   E. Develop a better understanding of why these parent support programs work.

Workshop: Elder Abuse

Recorder: Gene McGovern

In the elder abuse workshop four main topics were discussed: where we are now, some of the methods of treatment, the barriers to research, and suggestions for research. In regard to where are we now, one panel member stated that our present information about elder abuse is comparable to our knowledge of child abuse in the 1960s. We do know that the typical victim is female, 75 years old, may be ailing, is usually locked in a room, has no visitors, and makes no phone calls. She may or may not be beaten; she may or may not be sexually abused. She has her possessions taken. In 84 percent of the cases, it is a relative who abuses her. She has no place to turn to, and she has special physical- and/or mental-health needs.

Mental-health components of elder abuse include unresolved family conflict (the commonest violence in our society), high levels of family stress frequently existing before the abuse occurs, a lack of closeness between the dependent parent and the family, and the unavailability of services. Existing mental-health problems may be worsened by the addition of an older person in the family. The Harris Poll reveals that the older one gets, the less likely one is to be abused. In Texas, over a four-year period from 1982 to 1986, the reports of elder abuse escalated from 3,316 to 10,000 cases. Establishment of a hotline for reporting elder abuse during the latter part of this period leads to the conclusion that public awareness is a key to reporting. A reluctance to speak up limits reporting of cases. Regarding elder abuse in institutions, we know that shoving, pushing, inappropriate restraints, and inappropriate medications may be used. The real concern is for the unreported, invisible elderly; nobody knows who or how many they are. It is felt that community failure may be a cause of parent elder abuse.

In regard to methods of treatment, in institutions there is a need for education and training of workers; aides have the most contact with the elderly and are the least prepared in dealing with them. There is also a concern that intervention may cause as many problems as it provides solutions, because the model for dealing with elder abuse is the child-abuse model. We don't know enough about it yet. There is a need for a change in the laws so that individuals can sue for actual punitive damages; now the public prosecutor represents them. Monitoring of institutions by volunteers can be effective in preventing elder abuse. A home

for the elderly should have as its paramount concern the morale of the residents and good patient care. There are agencies involved with the concern for elder abuse, but there is a great deal still to be done. An example of this is the fact that at present there are no shelters for the abused elderly as there are for abused wives.

The primary barrier to research is lack of a widely accepted definition of elder abuse. Recording of elder abuse differs from state to state and there is no agreement on the definition of elder abuse. A widely accepted definition is needed for public policy purposes and it is felt that if researchers, policymakers, and practitioners could collaborate to define elder abuse it would have an impact for reporting and for appropriate intervention.

Suggestions for research included a national study of the incidence of elder abuse. There is a need for direct research with the victims rather than working with those that work with elder abuse. There is a need to study perpetrators. Case control or comparison group research designs were suggested. Questions as to the cause of injury to the elderly could be included in the National Health Interview Survey. It does inquire about injury but not necessarily the cause of it. There is a need for a systematic evaluation of existing intervention programs. Evaluation of existing and proposed public policies needs to be done for their impact on elder abuse. One panel member gave an anonymous quote: Any society can be judged by the way in which the powerful treat the powerless.

Workshop: Spouse Abuse

Recorder: Linda Bullock

Dr. Robert Geffner: A recent study on psychological and personality characteristics of battered women and batterers revealed risk factors for spouse abuse: 1) previous family history of violence; 2) low self-esteem; 3) being pregnant; and 4) unemployment. Research on characteristics of men and women involved in abusive relationships showed few psychological differences between batterers and battered; both are quite different from what we call the norm. Similar personality traits in both are low self-esteem, anger, hostility, impulsiveness, global distress, alcoholism, and submissiveness. Summary of other studies being done: 1) effects of criminal justice system (does arresting the batterer decrease the number of offenses?); 2) Angela Brown looking at women convicted of homicide (were they abused by the person they killed?); 3) significant association between alcoholism and battering; 4) effect of being a child witness on perpetuating the cycle of abuse; 5) ethnicity of the batterer and battered (no racial boundaries for perpetrators and victims, but ethnicity related to treatment and help received.); 6) deeper reasons why battering relationships evolve; 7) aspects of social psychology (aggression); and 8) sexual attitudes. Problems in research: 1) Whom is the sample going to evaluate? 2) Do researchers across the country use same definition of spouse abuse? 3) What are used as control groups? 4) How do we deal with ethical areas of spouse abuse? and 5) follow-up research in this area. Three new journals dealing with the issue: 1) *Journal of Family Violence*; 2) *Journal of Interpersonal Violence*; and 3) *Violence and Victims*.

JanaLee Sponberg: The face of the military has changed dramatically in the last 10 years. No longer drafting young single men, they are getting families. In 1981 the Department of Defense (DOD) created the Family Advocacy Program (child and spousal abuse) to 1) establish a family-advocacy committe (advocacy representative on each installation); 2) assign responsibility for and provide policy regarding family-advocacy issues; 3) specify common definitions; and 4) encourage development of programs contributing to healthy family life. The hallmarks of the Family Advocacy Program are 1) a family advocacy officer; 2) a multidisciplinary care managment team; 3) local implementing regulation/instruction (have just had a new directive due to recent research); 4) unit commander involvement; and 5) a civilian-military coordinator. Services provided in family advocacy include prevention, identification, reporting, intervention, treatment, evaluation, and follow-up. The Family Resource Center is a clearing house for military family research and policy office. Recently the DOD has developed a two-page intake form, designed to be used by all branches of the military.

Anne Helton: Research shows that of 290 healthy pregnant women interviewed in prenatal clinics, 15 percent had been physically abused before pregnancy, and an additional 8 percent had been physically abused during pregnancy. Four percent had been threatened. The typical battered pregnant woman is 1) white, black or Hispanic; 2) 24 years old or younger; 3) in her first or second pregnancy; 4) unemployed; 5) a high-school graduate; and 6) married. Eighty-eight percent of those battered during pregnancy had a history of prior abuse. Thirty-three percent of women battered during pregnancy had talked to a health-care provider as opposed to 5 percent battered prior to pregnancy. Men batter pregnant women because 1) pregnancy interrupts the powerbase for men; 2) during pregnancy the woman usually seeks outside health care and part of the battering cycle is isolation, so this may increase the violence; 3) the prenatal child-abuse factor; and 4) the defenselessness of pregnant woman.

Through a March of Dimes grant entitled Prevention of Battering during Pregnancy, obtained at Texas Woman's University, several educational materials have been developed: 1) a slide-tape show and a protocol booklet from the March of Dimes can be obtained from the national office, White Plains, New York, for $50.00; 2) a risk-assessment guide; and 3) posters (Spanish and English) directing battered women to talk to a nurse or physician. Policy changes due to the educational program include all new female patients coming to Harris County Hospital District clinics are now assessed for abuse and given appropriate written referrals, Methodist Hospital assesses all postpartum women for battering as part of the discharge process, and several other hospitals are in the process of instituting the same program.

JanaLee Sponberg: The Department of Defense denied for a long time that the military had problems in the area of family violence. But when they recognized the problem, officials moved very quickly to put the child and spouse together and to initiate programs. They are dealing with 500 thousand people in the military, so it is a mammoth program. They have their problems but the program has been a success. Moving from a more

punitive mode to a treatment mode. The military is approaching the problem in a multidisciplinary way. It is important to share information because of our highly mobile population.

Dr. Robert Geffner: Directions for the future include gathering, analyzing, and drafting research with objectivity; devising practical means to help victims; and drafting social and political policy, implications of first two weigh on this. All three areas need to be integrated and to involve people in all three fields. Research indicates shelters do some things but not others. They successfully protect women from immediate danger and meet safety needs and help empower women. They are unsuccessful because a significant percentage (perhaps over 50 percent) of women go back to violent relationships. The approach being taken now is in answer to women's response that they love their husbands, just want violence to stop. Some research shows that the spouse needs to be reintegrated into the relationship: that multifaceted approach is necessary. Research in California with conflict resolution has been somewhat successful. East Texas Crisis Center has multimodal domestic treatment program and the data on effectiveness are just now coming in. We know very little about the effectiveness of treatment programs in existence. One long-term goal is to find the antecedents of family violence. One of the most important things we can do is networking.

Abbie Meyering: The Southwest Family Institute uses a family approach. In 1979 police could not arrest unless there was a witness. Counseling, if sought, emphasized ways not to provoke the male. To get a restraining order, the woman had to file for divorce. In 1986 we have treatment for men, legislation for police arrests, and support for women. With all these things in place we can look at the actual violence. Civil suits were brought against police departments when hundreds of women complained that arrests were not being made. Restraining orders are not effective. Don't isolate couple behind closed doors. The Family Institute has a team approach, a twelve-week program of intensive work designed to end violence. Through a systems approach, we understand that intervention may set up more violence. Using a systems approach, you must keep in mind the many systems and that change must be in all. Out of twelve families, the center has had a 91 percent success rate in ending violence.

Dr. Jean Deschner: Over six years of experience it has found that when couples use "time-out" technique the violence stops. In the Fort Worth Anger Control Program, we taught the time-out technique to officers who would be dealing with domestic disturbances. A district in Fort Worth with the highest incidence of domestic violence calls was selected as an experimental group. The control group consisted of two districts in same area. In one the chief of police had a strict "let's-get-tough-and-arrest-them" approach to battering spouses. The steps in the time-out technique are 1) realize that emotions are rising; 2) quickly call a time-out; 3) let the other person go; 4) take a cooling off period from 20-30 minutes; and 5) each one admit a small fault. The results of the Fort Worth program were that 9 out of 12 officers said they were comfortable teaching the technique but refused to collect data, so study had to rely on report calls, then looked at the report calls in the

experimental and control groups. The other data base could have been the police logs, but because domestic violence is not an FBI directive, these calls are not logged. An unexpected result was that the police who were in the experimental group appear to have increased in knowledge about domestic violations, so citations were increased. However police showed extreme reluctance to arrest batterers. Two areas that we hope to change are FBI reporting of domestic violence and police attitudes on booking a man for battering.

Symposium: Issues Related to Victims of Violence

Recorder: Kenneth Zimmern

Who are the victims? Beyond the obvious victims, their numbers stretch to include emergency service personnel, relatives of victims, police officers, witnesses, anyone who has been touched by violence. The symposium set out to address the isolation, frustration, and needs of victims of violence. Moderator **Richard Collins** began the workshop by reminding the audience that someone is victimized by crime once every 26 seconds in the U.S.

Dr. Robert Pynoos from UCLA addressed the effects of violence on children. Evidently, children exposed to excessive trauma develop *post-traumatic stress disorder,* first recognized as a syndrome among Vietnam veterans returning home with unusual stress symptoms. In children, it is characterized by recurrent dreams or nightmares, emotional constriction or numbness, new behavior which mimics the trauma, i.e., assertiveness or imitation of sexual behavior.

The greatest stress symptons arose for children exposed to violence on the playground or at school. Other symptoms include sleeping disturbances, fear of reprisals, and grief reactions. A single violent event can have devastating ramifications for the future development of a child. Proper treatment is crucial. Three important treatment needs: immediate access to mental-health workers, human accountability, and closure/reintegration into society.

Dr. Michael Mantell reminded the workshop of the impact of violence on rescue workers and primary care personnel. Violence leaves a mark on the spirit. He contrasted the symptoms of emergency-care workers at the PSA plane crash in 1984 with the McDonald's massacre in 1985. Before crisis intervention with rescue workers, they developed significant mental/physical symptoms: 20 percent drug-related problems, 37 percent marital trouble, and 36 percent cardiac or gastrointestinal disorders. He indicated that because of crisis intervention, no officers were lost to stress disability. Their efforts were primarily related to stabilization, safety, ventilation, prediction, and preservation. It is vital to maintain communication with the media. The media should be considered a tool to educate the community. He concluded by calling for a national task force which would organize local agencies in case of such a disaster.

Dr. Roy Allen discussed the impact of emergency medicine on victims of violent crime, and presented a study done at Ben Taub Hospital from January 1 through May 1982. Dr. Allen concluded that many variables determine the outcome of the relationship between mortality and the number of EMTS procedures performed.

desAnges Eckert addressed the mobilization of local agencies, drawing on her experience with the Edmond, Oklahoma, post-office shooting. Things that victms and the mental-health center needed help with were 1) bridging the gap between processing and responding to the posttraumatic stress symptoms that employees were exhibiting; 2) bridging from that point to actual clinical testing and long-term treatment when needed; 3) struggling with the management/union relationship of emergency-care workers; 4) deteriorating job performance at the post office due to stress reactions; and 5) ways of studying and learning from this event while still continuing to provide the normal services of the mental-health center.

Patsy Day, President and Founder of a new organization called Victims Outreach, a group that helps surviving victims cope with their loss and other ensuing circumstances, related her own personal tragedy--the kidnapping and murder of her fourteen-year-old daughter. One of the first traumas for surviving victims is that many people try to find an explanation in the murder victim's behavior. An important outlet for victims is to be given permission to feel what they feel. Many people say, "Don't worry," etc., which compounds the anxiety and guilt of the survivor. Lowered self-esteem and feelings of isolation and loneliness are common among victims. Survivors require 18 to 24 months to stablize after a violent death; they continue to experience mental disorientation and fatigue and feel that they are going insane.

The criminal justice system often revictimizes the victim. She reported the widespread practice of giving subpoenas to victims and victims' families and then not calling them, to prevent them from influencing the jury by their presence in court.

Victims Outreach gives victims an outlet for their feelings, assists them through the investigation and trial process, works with the police and legal system to make them more sensitive to victims' needs, informs victims of their legal rights, offers telephone support, maintains a lending library on grief and overcoming victimization, and tries to educate the general public.

Conclusion: The entire panel called for a national task force which in the event of a crisis would be dispatched to empower and/or support local agencies already in place. This task force would facilitate the coordination of rescue workers, health professionals, mental-health professionals, the press and community leaders, thereby minimizing the devastation and ramifications of violence.

Workshop: Assault and Homicide

Dr. Deborah Prothrow-Stith: The usual homicide setting is among people who know each other, who are drinking, arguing, and have a gun. One of the best sources of assault data is the Northeast Ohio Trauma Study by Dr. Baronsit, published in the *American Journal of Public Health*. Emergency-room data reported four times the number of assaults reported to police in the same time period in the same standard metropolitan statistical area. The FBI collects data in the Uniform Crime Reports on assault and other categories, but not characteristic data as, for example, trauma. Assaults probably tend to be acquaintance-related, as do homicides, and attitudes toward acceptable levels of violence are important in understanding the situation. To design prevention strategies, we must improve our data-collection resources, particularly in the area of nonfatal assault.

Dr. Lee Brown: The homicide rate for Hispanics during 1976-1980 was more than 2.5 times that for the white population. A black person has a 1 in 21 chance of being a homicide victim. Most minorities are killed not during the commission of a crime or while being involved with drugs, but by people they know. There is no evidence to suggest biological factors in minority homicide, but much to relate socioeconomic and cultural factors. Studies link unemployment and homicide, violence and the media, and homicide and the ready accessibility of handguns. All this suggests that homicide in the minority community must be considered as more than just a problem for the police and the criminal justice system.

Dr. Paul Blackman: Criminologists divide homicide into two general categories: "primary," or assault-related and "secondary," or felon-related. A primary homicide is one that is not a result of some other felony, robbery, etc. Not only is clear data on these homicides unavailable, but about 25 percent remain unsolved. Although research findings are limited, there is some indication that the availability of guns serves to reduce the amount of assault in aggravated assault or homicide. Generally, homicides follow assaults; rarely does a previously nonviolent person commit assault or homicide. Men who externalize their aggressive natures outside the home also do so inside. Where firearms are more widely available, as in the rural areas of the United States, assaults are relatively infrequent and unlikely to involve firearms.

Dr. Deborah Prothrow-Stith: Conflict resolution has become part of the curriculum in Boston high schools. The students are asked to create a fight situation, and the fight is videotaped and analyzed. In the context of the classroom, students will buy into the ethos that the hero need not necessarily be a violent person; however, attitudes need to be changed in the home and community to confirm this new ethos. Prothrow-Stith advocates meeting with clergy, priests, police, schools and other community agents to get across the message that the hero doesn't have to fight. She also advocates working with hospitals in identification of high-risk patients in the hospital and emergency room and doing intervention through the school system.

Dr. Paul Blackman: The public-health approach to criminology often reflects more concern for making policy than for the accuracy, relevancy, or availability of data to support a policy. Theories should be tested more thoroughly before proposing a law or policy. Public-health professionals should make more local studies--urban, suburban, and rural, and collect assault data in the categories of circumstances, motives, relationships, weapons, etc. We need to know whether a gun or knife is selected over weapons that may make it harder to kill someone because the intention is to kill or because the motivation is only to threaten or injure. Researchers in public health and criminological professionals should become more concerned with the rights of individuals in planning their research and making policies. The epidemiological model may be inappropriate for studying assault and homicide because as yet it fails to take psychological factors into account.

Workshop: Rape and Sexual Assault

Recorder: Lynn Hester

Presentation and summary of state-of-the-art research and discussion of available data.

Dr. Ann Maney (moderator): Maney reviewed research in the field currently being sponsored by NIMH, including that of Dr. Shaline Shaw on antisocial and violent behavior. For research funding information she gave the phone number of Dr. Edgar Vaight, 301/443-3729.

Dr. Jennie McIntyre: She talked about her current NIMH-sponsored Rape Research Project, to find out where fears and dangers were greatest and study possibilities for prediction and resistance. Victms are the focus of her study of assault; should they resist or not? Most people believe that resistance ends in severe injury. Feminist women find the passive stance to be contrary to their beliefs. Research on resistance must address timing, sequence of events, outcomes. Circumstances for making decisions on whether or not to resist: public or isolated, social context, physical characteristics of offender and victim (age, size, physical strength, numbers, motivation). Media accounts of successful avoidance would be useful in changing the attitudes of women, police, etc. Most rape-related injuries are minor; serious injury with rape is 3 to 7 percent. Research must address whether injury occurs before or after rape. Studies made have included attempted rape with and without injury and completed rape with and without injury.

Dr. David Waller: Dr. Waller reviewed six studies that researched the long-term outcome of rape victims. Burgess and Halstrum (1974) spanned seven years to get recovery data. They found 74 percent back to normal, 37 percent of whom recovered in 3 months and 37 percent who took much longer. Twenty-six percent did not recover. Santiago et al. found similar percentages over 2 to 46 years. Becker et al. studied outcome

of sexual dysfunction, fear of sex, decreased desire. Santiago studied 11 situational factors (victim, reported counseling, offender prosecuted, etc.) and found no correlations with severity of long-term effects. Becker also noted this. Pappieau studied effect on victims of severity of assault versus support of victim (empathy, understanding, encouragement: nine behaviors in all). Police rated higher in empathy than physicians, and amount of overall support did not predict subsequent outcome. Frank et al. found that the personality of the victim plays a role in outcome. High self-esteem before rape versus characteristics of depression, adaptive versus nonadaptive personality. Paplin and Susskind found that stressfulness of the experience depended on its "meaning" for victim. Many victims blamed themselves for not preventing attack. Martha Burke of the Urban Institute studied influence of positive factors in individual's life situation. John Conte researched effect of sexual assault on children. Showed no clinical symtomatology; proponent of family therapy for survivors of incest.

Sue Kelly James: Most people who report to a rape-crisis center are willing to go to police. A Michigan study finds this increase in reporting is due to public awareness and center's influence. Number of men coming to centers is increasing. Rape is beginning to be seen as power issue, not sexual issue. Large number of children and adolescents and incest victims showing up at centers. Adult male rapes being seen: one male incest victim over 40 very bitter as adult; one male raped by acquaintance. Only one male in 17 willing to report to police and then only with much support from center. They are afraid their sexual preference will be suspect. They feel they are supposed to be able to take care of themselves, and they are afraid they won't be believed. Issue of Concern: assaults on mentally retarded, when reported, are difficult to prosecute.

Dr. Jennie McIntyre: Presently doing extension of earlier work with NIMH to develop a means of prediction of rape situations and ways to escape without injury. She found that the crime most feared by women is rape and/or sexual assault with the threat of injury and possible death as the measuring indicator. The research response to this was to investigate aspects of our culture that either promote or decrease the incidence of rape and/or sexual assault. The focus of Dr. McIntyre's study was to test ways in which females could use protective measures against assault. We know that only a very small percentage of rapes are actually reported. Earlier research has led to improved investigative research today with aspects of the circumstances surrounding the assault, for instance, the physical environment and cause of attack.

Sue Kelly James described her observations at the Dallas County Rape Crisis Center. Her focus was on special populations that she determined were not getting their needs met: adolescents, adult males, and mentally handicapped. Studies have clearly indicated that this form of sexual assault is the most common but least reported type of rape. Young victims feel that the lack of credibility is the major reason for not reporting; they think that no one will believe them. In her work with adult male rape victims, the lack of belief factor also

plays a major role in the low reporting. The male's response reaction to rape is the same as for females, i.e., great disbelief and denial.

Rapes of the mentally handicapped are very underreported. The Seattle Project, a two-year grant to investigate these individuals, identified 300 victims which they determined were only 20 percent of the total mentally handicapped rape/sex-assault victims. Although these individuals were in their late teens and early twenties, they had a lot in common with child sexual abuse victims. The circumstances were coercion, special needs for attention, their lack of power and authority, and the perpetrator's being someone they loved and trusted. In an inspiring video, we were able to see the Seattle Project curriculum in action with fine examples of preimposed teaching. It was noted that rape of the mentally retarded, even when reported, is difficult to prosecute due to lack of eyewitness. Ms. James's recommendations are for more education and efforts to meet the needs of special groups.

Dr. David Waller: Post-traumatic stress disorder has a relationship to rape and sexual assault. His focus was on factors and outcome to sexual assault that relate to long-term psychiatric care. He identified six different studies that researchers have undertaken to study these outcome factors of rape. Dr. Waller said that the personality of the victim was the key in factoring outcome, pre-assault versus post-assault. Post-traumatic stress disorder is not the inevitable clinical diagnosis specifically for rapes and sexual assault, but rather a syndrome applying to certain instances "in the event that it is out of the range of human experience and...psychologically traumatic; for example, serious threats on life, personal physical integrity, destruction of one's home or community, seeing another person who is mutilated, dying or dead, or the victim of physical violence." The syndrome features, first, a recognizable pressure that would evoke severe distress in anyone; second, a persistent re-experiencing of the trauma; third, a numbing of responsiveness to the outside world; and fourth, persistent symptoms of increased arousal, as in the startle reaction. There are three principal theories of etiology of the syndrome. The psychoanalytic theory suggests that there has been an extensive breach in the individual's protective shield against external stimuli and that by repeating the trauma in dreams and waking life, he or she is trying to transform the passive stance to the mastery stance. The learning theory is tied up with Pavlov's work on conditioning, and the psychobiological theory ascribes the numbness experienced as due to a lack of norepinephrine, a hormone that assists in transmitting nerve impulses. Different treatments for the syndrome based on the three theories include a desensitization process that uses reconditioning in trying to help a victim deal directly with what has happened, antidepressant drugs, and psychotherapy in which the victim's transferrence reaction to the therapist is important. Dr. Waller stressed the importance of examining why one person is more likely to experience the syndrome than another. He feels more research is necessary.

Workshop: Suicide

Recorder: Chris Selden

Judie Smith: It is important to use research to train counselors. More than 95 percent of callers to the Crisis Center are ambivalent about dying. One of the best preventives is education of family, friends, and community about warning signs, how to respond, where to go for help. There were 25 teen suicides in Dallas last year after all three networks showed teen suicide movies. Two studies were done in the aftermath of these tragedies. The Gould and Sheffner study looked at suicides and attempts in the two weeks following presentation of the movies. They found 14 suicides before the movies; 25 after. Could parents and hospitals have been biased? The Philips study noted increases in suicides in the week following news or feature articles on suicide and no decrease afterwards, with greatest occurrence among female teens. It didn't matter if information was general or specific. Should there be a news blackout about teen suicide? What effect does suicide prevention education in schools have? It is hard to say. It has been overgeneralized. A similar study in another town showed no correlation between TV programming and suicides.

Charles Vorkoper: There is too much dramatization about the subject of teenage suicide in the media; it is glamorized and made to be attractive to young people. Smith and Crawford (Kansas) studied the number of serious attempts at suicide and found it to be small. For each death in the total population they found 110 attempts. The elderly may be the highest risk group. There is a need for more support groups. Schneidman's book understands suicide from the inside. The bottom line is to be careful about using statistics.

Dr. Phil May: Suicide rates among native Americans are extremely high--90 per 100,000 as opposed to 15 per 100,000 in total population. Ninety percent are male. Suicide varies between tribes and between cohorts. In early research, many of the same variables, e.g., family disruption, more than one caretaker and caretakers too unstable, increased arrests, and divorce were found. Suicides had been arrested at early age and had attended boarding school. Fort Hall, Idaho, lowered its high suicide rate by a tribally operated holding center for young people at risk. There are three groups of Indians of varying degrees of community integration. Highest risk individuals are integrated into neither modern nor traditional society. The more acculturated the tribe, the higher the suicide rate. Navajos (medium integration) had lowest rate.

Dr. Doug Puryear: Suicide hospitalization should be considered for a range of serious and life-threatening behaviors, but all should be taken seriously and evaluated. Parkland sees about 1,000 per month. Twelve percent on MIW. Twelve percent total hospitalization rate. Nineteen suicides in 6 years (that they know about, i.e., in short time after failure to hospitalize.) The one thing that prevents suicide is relationship, rapport with the patient.

Risk factors must be evaluated to gauge how big a risk there is. Intervention goes hand-in-hand with the assessment. Mr. C. is a 39-year-old male. He was presented with a moderate overdose and diagnosed as depressed and was prescribed medication which is to be given out by his wife. The doctor explained depression to him. The more people can plug into the system, the better, e.g., family, friends, neighbors, employer, physician. Suicidal person has a narrow, rigid focus, can only see two options. Experts have wide variety of opinions about how responsible the therapist is for the suicidal person. It is important to know the history of losses in childhood in making a diagnosis. When getting the network involved, be specific about what you want from other practitioners.

Dr. Phil May: Suicide-prevention modes include 1) improvement of quality of life; 2) education of at-risk groups; and 3) crisis intervention. Dr. May discussed three models of crisis intervention. The first was Fort Hall, Idaho. In response to high suicide rates among young people, a tribal council created a holding facility manned by volunteer tribe members. They also received outside specialized support, e.g., psychiatrists. The second model was located in Pine Ridge, South Dakota. The hospital emergency facility initiated a 24-hour call system. They trained people in the community (e.g., police, teachers, etc.) to bring in anyone who made suicidal threats or gestures. The third model in New Mexico has tried to combine tribal and community efforts. This program's low overall rate of success has been largely due to an effort to serve three widely divergent cultural groups at once, but its one notable success has been in establishing a strong teen suicide prevention program in the high school. In general, programs need to be multifacted and tailor-made to the particular tribal situation. We need more research with families in which several problem areas tend to cluster. We need to study people who have become successes out of situations with poor outlook. We need more and better epidemiological studies. Tribal elders and women have very low rates of suicide. Why?

Charles Vorkoper: Survivor groups are a newer modality that is useful. Survivors have a particularly difficult time with anger they feel at the person who has committed suicide. It can be very difficult to get through the denial. There is a need to teach people that therapy works and not to spend so much time working caveats. There is a need to be sure that the therapist isn't suicidal. At the top of the list is coordination among the various agencies and organizations that are involved, (e.g., AA of Suicidology). *Suicide victim* is a poor choice of words. *Suicide success* is also a very poor choice. A dead person is a failure. Education should be used to make suicide a boring act and not to dramatize it. There is a need to educate the press and media about this. There is concern about the training of therapists--a lack of exposure to crisis intervention. Suicide among therapists is an especially serious matter. Physicians should be taught more about suicide because they are often contacted prior to suicide and need education about how to deal with it. The panel agreed on a recommendation to work with the media in an effort to deglamorize suicide.

Judie Smith: Recent research can guide our strategies in the three areas of prevention, intervention, and postvention. A coordinating agency is needed for the research. More

information is needed on the effects of TV viewing before making rash changes. The data collection system needs to be better. There is no setup for even knowing what the suicide rate is. Some outside evaluation of educational programs is needed to come up with a model program. School systems need to have a written policy about suicide. The crisis center has a staff of six but has trained a paraprofessional staff of over 100 people. They work on a day-to-day basis; not able to project needs and plan for them. The center has a survivors' group, as well as separate services for adolescents. Immediate outreach to survivors is advocated when there is a suicide. The elderly are not being reached although they are the highest risk group.

Workshop: Injuries Due to Risk-Taking Behavior

Recorder: Dan Farris

The focus of this conference has been on violence--purposeful and intentional behavior performed to hurt or injure another person. However, this workshop focused on accidents and the injuries received in the performance of activities not normally accepted as violence.

What causes individuals to engage in risk-taking behavior? Looking at risk-taking behavior as a disease, with an agent, host, and environment, what takes place in the host that allows the manifestation of this behavior? Has the behavior developed due to a lack of emotional nutrition from birth or perhaps an acting out for love, approval, friendship, etc., or is this behavior the result of thrill-seeking with no positive attributes?

Accidents are the fourth leading cause of death before the age of 65. What causes accidents? Can they be predicted? Who is most likely to have an accident? Is an accident an "act of God" or a "chance event"? Or both? Previous accident behavior seems to be a good indicator for future accidents. Certain groups seem prone to accidents, depending on social class, ethnicity, age, sex, marital status, personality. 1) Men's arrest rate is 10 times greater than women's for same crime. 2) Men DWIs are 10 times more likely to have accidents and be at fault. Even when controlled for "greater exposure to certain situations," accident rates are still higher. 3) Single men generally have more accidents. 4) Short-term stress seems to be a factor in accidents as well as long-term (pattern) proneness. 5) Generally, men underrate risk and overrate their capabilities.

The individual accident repeater is described as suicidal, self-destructive, undergoing recent or current stress, aggressive, impulsive, depressed, anxious, and extroverted. Preaccident behavior indicated as a rapid succession of simple mistakes not normally made with usually a prediction of injury from the individual.

Statistics gathered by the National Highway Traffic Safety Administration in the sixties revealed that "human element alone" was the major factor in 54 percent of accidents. The environment's contribution to an accident was not rated nearly as strongly as the human factor. Factors break down into social, physical, internal, and external, usually interacting with the human factor.

Chemical use seems to be the rite-of-passage into the adult world of the 80s. Are we seeing a learned pattern of adaptation in dealing with life's stress? It was felt that in order to understand and deal with the situation, a multidisciplinary stance will be needed. Chemical dependency usually includes a sincere delusion that no problem exists. A reprioritization of values and lifestyle, loss of control. Children and alcoholics have high risk of developing risk-taking behaviors. A typical Dallas Challenge case (70 percent) was described as a 15-to-17-year-old male brought in by his mother, who is the child of an alcoholic and married to alcoholic. The son is dating a girl who is a child of an alcoholic.

Alcohol is still the number-one drug of abuse in the U.S. Eighty-two percent of stabbings, 75 percent of shootings, 50 percent of accidental fatalities, and 48 percent of fatal car accidents are alcohol related. A drunken driver is three times more likely to die in an accident than a sober driver.

Although there is no method to test for THC level (reflecting marijuana use) in an accident victim, the effects on judgment, perception (time and distance), and braking are the same as with alcohol impairment or possibly worse. The effects of THC usually subside within 7 to 8 hours but have been noted up to 24 hours after use. Prescription drugs pose an even greater risk for health when mixed with alcohol. Can accidents be prevented by minimizing environmental causes? Can we identify accident-prone individuals beforehand? Individuals at risk may show evidence of depression, anxiety, beg for help, usually by small infractions of safety rules, usually feel something is wrong. Sometimes alcohol or drugs are used to mediate an unacceptable disability such as personal or family problems or an accident; then the syndrome sets in characterized by anger toward helping professional.

Can laws be effective, enforceable, reasonable, acceptable? Can sentencing be effective? Can advertising be effective? Targeted education was suggested for at-risk groups.

Community involvement must be a vital part of the success of any program. Efforts should be directed at the problem areas and tailored to the specific needs of the group or community being served. Intervention is needed in emergency rooms, hospitals, etc., dealing with the cause as well as the effect. Adolescents' involvement with a program will encourage success among their peers.

Conclusion: It will be a slow process at best, for we are dealing with reversing the education of individuals who are not aware of a problem. We must try to develop better methods for effective change. Whether we will ever be free of violence, intentional or not, remains to be seen, but more lives can be saved, more people remain whole (noninjured). It is worth the effort.

Panel Discussion: Regional Data Collection and Analysis

Recorder: Ann Gutierrez

Linda Lloyd: A grant proposal for a model for a regional data collection system was submitted. System should be comprised of 1) documentation of data, 2) characteristics of population, 3) characteristics of populations at risk, and 4) characteristics of population at

risk for handling stress in adverse situations. We need a data collection and analysis system that can generate and test hypotheses. Input should include any pertinent information given, such as pattern--who, what, when, and where; number of lives affected; number of lives lost; and number of dollars spent.

Public health is not the sole owner of violence. There needs to be community involvement, and violence needs to be considered a priority in the allocation of resources.

Dr. Gregory Istre: Practical and theoretical problems associated with data collection are found in the areas of adolescent suicide and prevention of adolescent and childhood injury. The intention in an injury may not be clear. Some motor vehicle accidents may be suicides and others due to alcohol, but medical treatment is the same whether the injury is intentional or not. The method of prevention may also be similar; therefore, we need to study both intentional and unintentional injuries. Areas that could be looked at are gun control, use of alcohol/drugs, and also risk-taking behavior. We also need to collect data on both the victim and the perpetrator. Death certificates looked at during 1978-84 showed over 18,000 deaths from injury, of which half were due to unintentional injury and the other half to suicide and homicide. Mortality from homicide and suicide was the greatest reason for deaths among young black males.

Often epidemiological studies need to link several sources of data: death certificiates, medical records, etc., and if certain persons are systematically excluded from the records or misplaced, then enough bias may be present to make conclusions erroneous. The statement that persons in rural areas are statistically less likely to die from a gunshot is probably influenced by the fact that in rural areas a gunshot might not be recorded. Confidentiality is a problem in interagency sharing of data. The number of sources of data available to public-health personnel need to be increased. Nonfatal incidents of violence need to be studied. The future is bright for application of the traditional public-health approach.

Suzanne Danilson: Health professionals have a larger role in child abuse than just reporting. Once we report suspected cases, some feel that our responsibility ends. We all have a role in data collection. We need to know when child abuse and neglect occur, the rate of child and infant mortality, and the number of confirmed cases of child abuse and neglect. Our goals for child health should be 1) to improve and maintain the health of the child and family, 2) to monitor child health, and 3) to decrease the amount of child mortality. Physicians, nurses, and social workers must look for means of intervention at the primary, secondary, and tertiary levels of prevention. Child sexual abuse is a complex problem requiring expertise and a multidisciplinary approach. All agencies need to work together to protect the child, to report cases, and to be an advocate for the child and/or parent. We need to collect data on means of intervention and child fatality cases. We need to look at child protection agencies first. In order to report abuse effectively, health care and other personnel need to be able to identify it correctly. There is no set definition for child abuse and neglect. To establish a definition, look at the definition that the mandated child-protection agency in your area uses. If an agency does not have a definition, it needs

one. Look at general definitions, and look in state statutes for a legal definition. We need definitions for different types of neglect, abuse, and sexual abuse. We also need operational definitions when collecting data so that there is no problem with interpretations.

A number of states have developed a sophisticated reporting and tracking system for data. Illinois has a system of recording that has increased the number of reports from physicians, nurses, and social workers, making it possible for them to be able to intervene earlier with a result of decreased child mortaility. Louisiana has a statewide reporting system in the protective agency which they adopted from the Illinois system. The Illinois system was also adopted in Rhode Island. The Illinois system has over 50 operational definitions of abuse and neglect.

One data collection agency reports a 38 percent subsantiation rate. This does not mean whether or not a case was found valid. Nonsubstantiation usually means that there was not enough evidence.

Dr. Jonathan Sheline: Two important tools in data collection and analysis are 1) ability to download data to a personal computer and 2) linking of data bases. A good person is needed in data processing to extract usable information.

His study on suicide in New Mexico from 1962 to 1984 was made possible by learning how to download data from Vital Statistics mortality files to floppy discs. They coded variables of age, sex, ethnicity, tribe, etc., and used three time periods based on three changes in the death certificate form. Suicide patterns vary substantially among New Mexico's three ethnic groups. Suicide by hanging was the most frequent method among the native American population. The suicide rate for this group increased three times between 1980 and 1984, especially among males. Ethnicity may be a risk factor for suicide in the state.

A study by David Fleming of the Oregon Department of Health linked three sources of data: vital records, office of medical investigation records, and police motor vehicle accident records. The study looked at two reasons for death among the native Americans: pedestrian death and exposure (hypothermia). The profile for pedestrian deaths is 1) children not much higher than adults; 2) impaired near car; and 3) adult near car. The profile for someone at risk for hypothermia is 1) adult; 2) health; 3) highly intoxicated; 4) away from home; 5) away from car; and 6) near/off reservation bar. The advantage of being able to link the police report with other data is that it gives the mile marker which reveals that a high number of deaths by hypothermia occurred near off-reservation bars, thereby affording a clue as to cause.

Charles McGrew: FBI Uniform Crime Report System is criticized for inaccuracy of data, lack of detailed information, and not enough analysis and interpretation. There is a problem in comparing that data to other data. The Department of Justice and FBI are currently open to looking at new ways of data collection, and we should all give them input. They are proposing a two-level system of reporting. All cities are in level 1, and selected cities amplify data in level 2.

The data we get should be used in educating people who have little idea of the problems we face. Trying to interpret the statistics to show legislators how their state ranks can be tricky; they might look pretty good on the state comparison level, but a comparison of major cities with those of other states might tell a different story.

We need to be cautious about handguns. Most people in our region have very strong feelings on this issue. We need to move forward as quickly as possible to collect data, but we must be very cautious and make sure we get good data.

Dr. Ralph Frankowski: Surveillance is changing in form and shape and it is important that we define it. Surveillance was originally defined as keeping close watch over individuals or groups to detect a problem. Later it was a watch or guard of a suspected person. In public health it was originally the process that led to quarantine. Until 1950 surveillance was restricted to watching contacts of disease so treatment could be initiated; however, in 1950 the object of surveillance became the disease itself. Today surveillance could be defined as 1) a system for collection of relevant data; 2) constant evaluation; 3) prompt dissemination to all who need to know; 4) responsible alertness; and 5) responsible action upon predication. We need continous monitoring of data from patterns, and we need a good quality of data. The type of information that we need is more important than quantity. We need preevent, event, and postevent information. Events surrounding the incident are important. We should look at 1) vital statisitics (important but not enough); 2) mortality data; 3) child abuse reports; 4) law enforcement data (agencies should get together to talk about their common goals early in this new formulation of the FBI uniform crime report); and 5) population-based surveillance. There is a glimmer of hope for the difficult task of population-based surveillance with the health-maintenance organizations, which are working with a defined population, well-known and under a constant microscope of medical service utilization.

The challenge in surveillance is not only to collect and collate data but to be able to present it to officials, politicians, and the public so as to achieve effective action and then to evaluate our efforts.

Symposium: The Costs of Violence and Its Impact Upon Future Legislation

Diane Ragsdale [Mayor pro tem of Dallas]: Dallas has historically been near the top in total indexed crime per one thousand population. In a period of 10 percent increase in population, requests for police service increased by 52.7 percent. According to the mayor's "Criminal Justice Task Force Report", the chronic recidivist or repeat offender committed an estimated 61 percent of the crimes, which cost Dallas County an estimated 155 million dollars. Texas spends less per capita than any other state in the nation on drug- and alcohol-abuse prevention programs and crime-prevention programs, and ranks 29th in the nation on dollars per student for education. She calls for more money for education and more of the aforementioned prevention programs.

Dr. Louis DeNino: We are aware of the costs of criminal justice, prisons, and monetary assistance to victims which are borne by taxpayers; but we often fail to recognize that public funds underwrite a large portion of the medical and other rehabilitation costs of violence. His pilot study (described at length in his paper included in this volume) at Ben Taub Hospital in Harris County was aimed at estimating the medical costs of violence that are absorbed by a public hospital. Over a period of one month, they tracked victims starting with emergency medical service records all the way through outpatient services. The hospital charge was adjusted to actual costs by using a cost-to-charge ratio of 4/5, provided by the hospital administrator, and costs were computed in each of the three main categories; gunshot wounds, stabbings, and aggravated assault.

The results of the pilot study were as follows: it demonstrated first of all that it is possible to use hospital records to estimate in-hospital costs of violence. They found that the total cost was heavily influenced by a small number of serious cases (a majority of individual patients were well below $500 in in-hospital costs). The study also demonstrated that a significant portion of the costs was borne by taxpayers.

Dr. Catalina Garcia: After talking to returning Vietnam veterans, she felt that she had seen everything in a Dallas emergency room that they had seen in the war. She has learned firsthand that we are a very violent society. She believes that many victims of violence do not show up in the statistics, which makes it difficult to compute the cost of violence. She measures the cost of domestic violence in people-years, says the primary cause of death in the young age groups is accidents.

She compared violence with the infectious diseases that have been eradicated over the past century and pointed out that many years before immunizations or antibiotics were developed, people had started figuring out some of the sociological causes of the diseases and made a lot of progress merely by dealing with overcrowding, malnutrition, and unclean water.

She computed the cost of one case of family abuse in Dallas--protective order, legal fees, police calls, loss of work time, emergency room and hospital costs, property damage, shelter care, AFDC payments, and food stamps--at nearly $4,000.

Dr. Daniel W. Shuman: We are all sickened by violence and especially by violence against children, but prosecuting instances of child abuse presents some difficult legal problems. The child may be physically unable to testify because of infancy or physical consequences of abuse or may not be old enought legally to testify. Even if the child does testify, her or his testimony may be suspect. Furthermore, the charge of child abuse is becoming a handy tool for such people as divorcing spouses who are trying to discredit each other.

The criteria that have been developed by child-abuse experts are often misleading and unreliable. The research on the subject is largely anecdotal, and the American Psychiatric Association does not even have a definition of a battering-parent syndrome in its diagnostic and statistical manual. Studies that do incorporate statistics tend to contradict each other. A test or diagnostic tool that attempts to identify child abusers must be evaluated

on the basis of its sensitivity (i.e., ability to identify child abusers) and its specificity (ability not to erroneously label as an abuser someone who is not). An error in sensitivity is called a false negative; an error in specificity is called a false positive.

A study was conducted in Tennessee in which 1,400 women who were soon to give birth were interviewed in an attempt to identify people who met preestablished criteria for potential child abusers. Two years later they searched the state central registry that would include all reported cases of child abuse. They found that 2 percent of all the 1,400 had abused their children. Of the 273 that had been predicted to abuse, 6 percent had had reports filed on them. Thus if you made a prediction that someone was going to abuse based on these criteria, you would be wrong 94 percent of the time--the false positives. The other question--the false negatives--is, did it catch all the people in the population who are child abusers? There were 30 child abusers; of these, half were found in the likely abuser population and half in the "normal" population.

The study was a reasonable one for the use it was to be put to, i.e., selection for preventive counseling; however, to use the same criteria for courtroom identification in which someone's child may be taken away or someone may be sent to jail, a higher accuracy rate is essential. "To use bad scientific research or scientific research that was never designed to be used in a judicial context in order to salve our collective conscience that we have adequately addressed the problem of child abuse, does not do so."

Part VIII

◊ **Appendix A**
Address of Appreciation
by Robert G. McGovern,
Chairman of Steering Committee

◊ **Appendix B**
Program Schedule

◊ **Appendix C**
Academic Papers Presented at Conference

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Appendix A

Address of Appreciation

Dr. Robert McGovern, Chairman of the Steering Committee
Summary Session, November 8, 1986

It would be remiss of me not to say a few words of appreciation to some very special people and also to make you aware of some of the dynamics that went on in preparation of this program. The first person that I want to thank with all my heart is my wife Genie for being so understanding. I want to thank Susan Eldridge who has been the head of our volunteer program for this conference. Ms. Eldridge is typical of the wonderful volunteers we have in the community of Dallas. Thirdly, Annette Zimmern and her husband Jim. The last time we four met was Sunday morning, hoping we had this job all tied together. It was exciting. I want to thank Ann Harrel and Cari Nolan, who were our entire publicity department. Thank you too, all of you folks in Oklahoma, New Mexico, Louisiana, Texas, and Arkansas who were willing to go to any radio or TV station to promote this conference. Finally, thank you June Bovill. June runs our continuing education department. She has been superb.

Now some other people that I really want to mention. One certainly is Dr. Charles Sprague, who has just recently stepped down as President of our Health Science Center. Tonight there is a dinner being sponsored by the Dallas County Medical Society for our two Nobel Prize winners. Whereas in no way do I want to underestimate how important cholesterol metabolism is, it is also important to note that the same Health Science Center is just as concerned about social and community problems, such as those we have been discussing here the last few days. Under Dr. Sprague's leadership this Health Science Center has shown and continues to show that balance of concern.

One other very special Dallas person, Harry Tanner, has been so helpful. For many years Harry has been the Executive Director of the Community Council of Dallas. In addition to being a valuable member of our steering committee, he introduced me to many of the wonderful, caring people in this Dallas community that make good things happen.

Tom Lalley, of NIMH, one of our consultants, is the person who first got us involved in the problem of violence. Tom has been extremely supportive and helpful. He has dedicated considerable time to this effort.

Ted Cron, Special Assistant to the Surgeon General, first drew our interest to this particular program. In 1985, we received a call from Ted inviting me to participate in planning a violence workshop in Leesburg, Virginia. I told Mr. Cron, "I know little or nothing about violence." He replied, "That's exactly our problem, we don't understand it."

Dr. Larry Hebert from the state of Louisiana, thank you. One year ago we called the APA seeking the best child-abuse specialist in Louisiana. In addition, Larry has also turned out to be one of the most caring pediatricians I have met.

Sarah DePersio, Director of Maternal and Child Health in Oklahoma, and Jeff Davis, Director of Maternal and Child Health in New Mexico, both served on the conference steering committee. Clift Price, whom I met many years ago, during internship, is our Health Department representative in Texas. We thank these three doctors for their enthusiasm, their many contributions, and their direction.

Susan Danilson and Charles McGrew, I am so sorry that we got to you so late in the development of this program. We really appreciate having you aboard. If a Southwest Data Collecting System is established, your continued help will be absolutely essential.

Fernando Guerra of San Antonio is a pediatrician, and for you who don't know him, he is a most productive gentle activist. He is also famous for his breakfast broadcast, which came from Mario's Restaurant in San Antonio promoting this effort.

Thank you, Hank Vader of the United States Air Force. He is the person who introduced the military into this program. Hank was an enthusiast from the very first meeting in Leesburg one year ago.

I thank Dr. John Dyer for the support we received from the regional office. You and your staff helped us in so many ways.

I want to express my appreciation to the great bunch of people from Houston. The people that I have gotten to know well are Dr. Blair Justice, Chairperson for the University of Texas Health Center at Houston Violence Committee; Lee Brown, Chief of Police in Houston; and Dr. Ralph Frankowski, one of the most knowledgeable people I know in the field of violence management and prevention. They have had an effective interdisciplinary committee on violence in Houston for some time. They are also establishing a research center which will deal mainly with injury and violence for this area. I don't think we can emphasize enough how important research is going to be if we are going to have accepted the changes necessary in this field.

I thank Joe Warshaw, Director, Department of Pediatrics, Southwestern Medical School and Mark Rosenberg of CDC. Both have been most supportive. During the conference Mark Rosenberg made the comment, "We have all these problems, but where is the research money?" Indeed the way we shall best demonstrate to the academic community the importance of this issue will be by way of excellent research.

Finally thank you everyone who attended this Dallas "Violence in America" Conference. I hope we have provided you with what you have been seeking. This has been the first regional effort to combat what Dr. Koop has described as a "Violence Epidemic." It will not be the last.

Robert G. McGovern, M.D.
Chairman, Violence Conference
Steering Committee

Appendix B

Violence in America Program Schedule

Thursday, November 6, 1986

9:00 a.m. to 11:45 a.m.

Plenary Session

Chairman	Kenneth Z. Altshuler, M.D., Professor and Chairman, Psychiatry, UTHSCD
Welcome	Mayor and Mrs. Starke Taylor, Dallas
Opening Address	**Violence as a Health Problem in the Southwest**
	Shervert Frazier, M.D., Director, National Institute of Mental Health
Plenary Address	**The Life Cycle of Violence**
	Larry Hebert, M.D., Professor of Pediatrics Louisiana State University Medical College
Plenary Address	**The Life Cycle of Violence**
	Herbert Nickens, M.D., Director, U. S. Office of Minority Health

12:00 noon

Luncheon Address	**Violence as a National Health Problem**
Introduction	Roger Bulger, M.D., President, UTHSCH
Major Address	Faye G. Abdellah, R.N., Ed.D. , Deputy Surgeon General, U.S. Public Health Service

1:30 p.m. to 3:15 p.m.

Symposium	**Violence as a Special Health Problem for Minorities**
Moderator	Everett Rhoades, M.D.Indian Health Service
Panelists	Fernando Guerra, M.D., Pediatrician Joseph Little, LL.B., Bureau of Indian Affairs Ronald E. Cowart, Dallas Police Department Ruth E. Dennis, Ph.D., Meharry Medical College

1:30 p.m. to 3:15 p.m.

Workshop	**Assault and Homicide**
Panelists	Judge Edward Kinkeade, 4th District Court of Dallas Deborah Prothrow-Stith, M.D., Boston University Lee Brown, Ph.D., Houston Police Department Paul Blackman, Ph.D., National Rifle Association

1:30 p.m. to 3:15 p.m.

Workshop	**Child Sexual Abuse**
Moderator	John Dyer, M.D., M.P.H., Region VI, USPHS
Panelists	Carolyn Newberger, Ed.D, Harvard Medical Larry Hebert, M.D., Louisiana State University Medical College Paul Prescott, M.D., UTHSCD
Workshop	**Child Abuse**
Moderator	Lt. Col. Hank Vader, U.S. Air Force Eli Newberger, M.D., Harvard Medical College Blair Justice, Ph.D., UTHSCH J.P. Flanzer, D.S.W., University of Arkansas
Workshop	**Elder Abuse**
Moderator	Faye Abdellah, R.N., Ed.D. USPHS
Panelists	Karl Pillemer, Ph.d., University of New Hampshire Bert K. Smith, Ph.D., Hogg Foundation, Houston Clairece Feagin, Leg. Asst. to Sen. Gonzalo Barrientos, Austin

3:30 p.m. to 5:15 p.m.

Symposium	**Issues Related to Victims of Violence**
Moderator	Richard Collins, Presdient, Associated Texans Against Crime
Panelists	Robert S. Pynoos, Ph.D., UCLA Michael R. Mantell, Ph.D., San Diego Police Department desAnges Eckert, M.P.A., Oklahoma Department of Mental Health Patsy Day, President, Victims Outreach of Dallas Roy B. Allen, Ph.d., UTHSCH

3:30 p.m. to 5:15 p.m.

Workshop	**Rape and Sexual Assault**
Moderator	Ann Maney, Ph.d., HRPH/OPAC, NIMH
Panelists	Jennie McIntyre, Ph.D., University of Maryland Sue Kelly James, M.S., Rape Crisis Center of Dallas David Waller, M.D., UTHSCD
Workshop	**Spouse Abuse**
Moderator	Thomas Lalley, M.A. NIMH (Consultant)
Panelists	JanaLee Sponberg, M.A., Department of Defense Robert Geffner, Ph.D., UT at Tyler Anne Helton, R.N., Texas Woman's University

4:00 p.m.to 5:15 p.m.

Workshop	**Suicide**
Moderator	Jeffrey Davis, M.D., MCH, New Mexico
Panelists	Phil May, Ph.D., University of New Mexico Douglas Puryear, M.D., UTHSCD Charles Vorkoper, A.C.S.W., Dallas Judie Smith, Director of Education Service, Suicide and Crisis Center, Dallas
Workshop	**Injuries Due to Risk-Taking Behavior**
Moderator:	Clift Price, M.D., Texas Department of Health
Panelists:	Arthur Funke, Ph.d., MCH, USPHS (Consultant) Martha Williams, Ph.D., UT at Austin Mike Cavender, Dallas Challenge

Second Day Program Schedule

Friday, November 7, 1986

8:30 a.m. to 9:15 a.m.

Plenary Session

Chairman	Joseph Warshaw, M.D., Professor and Chairman, Pediatrics UTHSCD
Plenary Address	**Learning from Patterns of Violence** Mark Rosenberg, M.D., Chief, Violence Epid Branch/CDC

9:15 a.m.to 11:00 a.m.

Panel:	**Regional Data Collection and Analysis**
Chairman:	Linda Lloyd, M.S.W., TCH
Panelists:	Gregory Istre, M.D., Oklahoma Jonathan Sheline, M.D., New Mexico Suzanne Danilson, M.S.W., Louisiana Charles McGrew, M.P.H.A., Arkansas Ralph Frankowski, Ph.D., Texas

11:15 a.m. to 12:00 noon

Plenary Session	**Homicide and Assaultive Violence** Keith Harries, Ph.D., Professor of Geography University of Maryland

12:15 p.m.to 2:00 p.m.

Introduction	Kern Wildenthal, M.D., President, UTHSCD
Luncheon Address	**Victims of Violence** Lois Haight Herrington, J.D. former Assistant Attorney General

2:00 p.m. to 3:45 p.m.

Symposium:	**The Costs of Violence and its Impact Upon Future Legislation**
Moderator:	Eddie Bernice Johnson, State Representative, Texas

Panelists:	Louis DeNino, Ph.D., UTHSCH Diane Ragsdale, Deputy Mayor Pro Tem, Dallas Catalina Esperanza Garcia, M.D., Dallas Mark Rosenberg, M.D., CDC (Consultant) Daniel W. Shuman, J.D., SMU School of Law

2:00 p.m. to 3:45 p.m.

Workshop:	**Assault and Homicide**
Moderator:	Judge Edward Kinkeade, 4th District Court of Dallas
Panelists:	Deborah Prothrow-Stith, M.D, Boston University Lee Brown, Ph.D., Houston Police Deparment Paul Blackman, Ph.D., National Rifle Association
Workshop:	**Child Sexual Abuse**
Moderator:	John Dyer, M.D., M.P.H., Region VI, USPHS
Panelists:	Carolyn Newberger, Ed.,D., Harvard Medical College Larry Hebert, M.D., Louisana State University Medical College Paul Prescott, M.D., UTHSCD
Workshop:	**Suicide**
Moderator:	Jeffrey Davis, M.D., MCH, New Mexico
Panelists:	Phil May, Ph.D., University of New Mexico Douglas Puryear, M.D., UTHSCD Charles Vorkoper, A.C.S.W. Dallas Judie Smith, Director of Education Service, Suicide and Crisis Center, Dallas
Workshop:	**Elder Abuse**
Moderator:	Faye Abedellah, R.N., Ed., D. USPHS
Panelists:	Karl Phillemer, Ph.D., University of New Hampshire Bert K. Smith, Ph.D., Hogg Foundation, Houston Clairence Feagin, leg. asst. to Sen. Barrientos, Austin

4:00 p.m.to 5:45 p.m.

Workshop:	**Injuries Due to Risk Taking Behavior**
Moderator:	Clift Price, M.D., Texas Department of Health

Panelists:	Arthur Funke, Ph.D., MCH, USPHS (Consultant) Martha Williams, Ph.D., UT at Austin Mike Cavender, President, Dallas Challenge Ron Anderson, M.D., Parkland Memorial Hospital
Workshop:	**Spouse Abuse**
Moderator:	Thomas Lalley, M.A., NIMH (Consultant)
Panelists:	Janalee Sponberg, M.A., Department of Defense Robert Geffner, Ph.D., UT at Tyler Jeanne P. Deschner, Ph.D., UT at Arlington Abbie Myering, M.S., Southwest Family Institute,Dallas
Workshop:	**Rape and Sexual Assault**
Moderator:	Ann Maney, Ph.D., HRBP/OPAC, NIMH Jennie McIntyre, Ph.D., University of Maryland Sue Kelly James, M.S., Rape Crisis Center, Dallas David Waller, M.D., UTHSCD
Workshop:	**Child Abuse**
Moderator:	Lt. Col. Hank Vader, M.S.W., U.S. Air Force
Panelists:	Eli Newberger, M.D., Harvard Medical College Blair Justice, Ph.D., UTHSCH J.P. Flanzer, D.S.W., University of Arkansas

Third Day Program Schedule

Saturday, November 8, 1986

8:30 a.m. to 10:00 a.m.

Summary of Workshops and Symposia by Recorders

10:00 a.m. to 12:00 noon

Discussion of Regional Data Collection

Leader:	Linda Lloyd, Epidemiologist
State Representatives:	Gregory Istre, M.D., Oklahoma Jonathan Sheline, M.D., New Mexico Ralph Frankowski, Ph.D., Texas Charles McGrew, M.P.H.A., Arkansas Suzanne Danilson, M.S.W., Louisiana

Appendix C

Academic Papers Presented at Conference

Criminal Homicide Assault: A Criminological Perspective

Paul H. Blackman

Although it is sometimes incorrectly assumed that criminal homicide is simply a criminal assault with a fatal end and that assault is thus an incomplete murder, the two are frequently quite different offenses. Legally, an assault with a weapon includes an offer to do grave bodily harm, whether the weapon is used, or attempted to be used, actually to inflict injury or not. Clearly, any threat which is not followed at least by an attempt to inflict the threatened injury or death is not simply an incompleted homicide.

Criminologists frequently divide homicides into two general categories, which may fluctuate in precise meaning. One category is called primary, or assault-related, and is often considered "argument-related" even though there are really inadequate data for determining the motivation of killers. The FBI simply does not collect precise enough information on the circumstances of homicide to allow a conclusion that "primary" homicides are argument related. All that can really be said is that the killing does not appear to be incidental to some other type of crime, such as robbery. The other type of homicide is called secondary, or felony-related; here it is presumed that the primary crime was some felony--robbery most of the time--and that the homicide resulted either because the criminal got frightened, or did not want witnesses, or for any other reason.

Phenomena arguing for these two basic types of homicide are seasonal trends as reported by the FBI's Uniform Crime Reports. Aggravated assaults are most likely to occur in summer months, with robbery peaking in December. Criminal homicide has two peaks, the summer months--when aggravated assault is high--and December--when aggravated assault is quite low but robbery and burglary are high. If murder were simply a completed assault, the winter high would be inexplicable.

In addition to these two generally recognized types of homicide, there may be other distinctions drawn. One common distinction involves the perpetrator/victim relationship. Again, there is a lack of clear data on the subject, at least at the national level, enhanced by the large percentage of unsolved homicides. (At least one quarter of reported criminal homicides are not solved by police in America; most other industrialized nations solve over 90 percent of reported criminal homicides.) The "family" and "stranger" categories are fairly clear, but the "friend, neighbor, acquaintance, other known" category is overly broad and indistinct, including persons who have only a nodding acquaintance as well as former spouses and current homosexual lovers. Generally, urban homicides are more likely to involve strangers, and to involve robbery or other felonies. Whites are more apt to be victims of felony homicides, stranger homicides, and domestic (family) homicides, while blacks are more likely than whites to be the victims of assault, primary homicide or

homicide reported to be committed by friends and acquaintances more than by family or strangers. Women are more apt than men to be killed by family members.

In addition to this categorization, there is another distinction regarding drug involvement in homicide. Drugs may be involved in any type of homicide, whether assault-related or robbery-related, and involving persons with any relationship. Drugs, in the 1960s to 1980s, like alcohol in the 1920s, are closely tied to fluctuations in the criminal homicide rate. Also tied to such fluctuations are felony-related homicides. Proscribed items and activities are thus related to felony homicides and to the use of guns in homicides, by those criminals whom no scholars believe would be disarmed by restrictive gun laws. There is, indeed, some concern that if gun laws were restrictive enough (like other proscribed items) to invite organized crime into the black or gray market, the gun laws themselves might raise the homicide rate. (An area which has not yet received adequate research is the extent to which the combination of gun running and drug smuggling in Mexico helps to explain that country's extraordinarily high rate of homicide.)

Another type of criminal homicide, as reported by the FBI, is that which is either excusable or altruistic. It is likely that at least 10 percent and possibly more like 25 percent of the homicides reported in the United States each year are actually self-defense or otherwise excusable homicides; the FBI asks local and state law enforcement agencies to exclude "justifiable" homicides from the "murder and nonnegligent manslaughter" category but not self-defense killings (Blackman and Gardiner 1986). Similarly included in the reported criminal homicides are mercy killings. Very little is known about the nature and extent of mercy killings or other altruistic killings, or about criminal homicides with such extenuating circumstances as domestic violence. We do know that in American prisons female prisoners are disproportionately incarcerated for murder or manslaughter convictions relative to male prisoners.

With regard to all types of homicides and assaults, very little is known about the motivations of the assailant. Criminological studies have simply failed as yet to determine what portion of homicides were intentional killings and which were unintentional, or what percentage of aggravated assaults were attempts to kill, what percentage to injure seriously, and what percentage were not really intended to cause any serious bodily harm. It is unknown, thus, whether a gun or knife is selected over weapons with which it may be more difficult to commit a murder because the intention is to kill, or whether the motivation is to threaten or injure and death results simply because of the nature of the weapon chosen. There is some evidence that weapons generally perceived as more dangerous are selected for some purposes in order to minimize the likelihood of injury or death. A major felon survey found that one of the reasons given for using a gun (or knife) to commit certain crimes was to avoid the necessity or likelihood of hurting the intended victim (Wright and Rossi 1986).

Victimization surveys conducted for the U.S. Department of Justice indicate that injuries from assaults (and robberies) are least likely when a firearm is used, somewhat more likely when a knife is used, and most likely when other weapons or no weapons are used. Although research findings are so far limited, there is some indication that the availability of guns, or to a lesser extent knives, serve to reduce the amount of assault and

assault-related injury, deterring assaults for fear of escalation of an assault to aggravated assault or homicide. At any rate, available information suggests that reducing the availability of firearms would increase the number of assaults and the number of assault-related injuries.

Reducing the number of handguns available would have still more problematic results. Felony-related murders are apt to involve persons who would be expected by virtually all scholars and advocates on either side of the "gun control" debate to acquire handguns if they wanted them regardless of any law. And, since family and argument-related homicides are more apt to occur in the home, where long guns may be more available and concealability is irrelevant, any policy which reduced the availability of handguns relative to long guns could spur assailants to use long guns. At close range, torso injuries inflicted by long guns are generally much more serious than similar injuries inflicted through the misuse of handguns. To the extent that gunshot assaults lack a clear motivation to kill, any policy which encouraged a switch from handguns to long guns would be expected to increase the assault-related homicide rate (Kleck 1986).

A policy which reduced firearms availability to the general public would also have the effect of reducing gun use for protection. Survey research (conducted by Peter Hart Associates for the National Alliance Against Violence, by Decision Making Information for the NRA, and by Cambridge Reports for the Center for the Study and Prevention of Handgun Violence) suggests that around 350,000 handgun owners each year use a handgun for protection from a crime, plus an additional number who use a long gun. While the victimization surveys report only infrequent uses of guns or knives for protection from assault, that protective measure is associated with slightly lower levels of injury to the intended victim than is the case with an assault when no protective measures, or measures other than weapons use, were reported. Although the FBI data are limited, "justifiable" homicides are significantly more apt to involve handguns than are suspected criminal homicides (some of which are actually excusable protective homicides). A restrictive gun policy, to the unexpected extent to which it was effective, could have the undesired side-effects of increasing the number of assaults and assault-related injuries while reducing the number of protective uses of firearms.

A survey of felons indicates that they are unaffected by various gun laws in American states, as well as by existing federal restrictions (Wright and Rossi 1986). And the limited data from other countries suggest the lack of a relationship between gun laws and gun use in crime; the percentage involvement of firearms in British homicides, for example, is the same now as prior to adoption of restrictive gun laws. Canadian homicide data suggest merely a slight shift from handguns to shotguns and an increasing firearms homicide rate.

While motivation to commit various crimes remains unknown, criminologists have found considerable data on the types of persons who commit assaults and homicides. Generally, homicide follows a history of assault. It is rarely spontaneous criminal behavior by a previously nonviolent person. Most domestic killings have been preceded by at least one and often by at least five prior police calls for domestic disturbances (Kleck 1986; Kates 1984). The FBI's study of the careers of criminals (included up to 1975) indicated

that the longest criminal career is among those persons arrested for aggravated assault. Among the key findings is that the distinction between "stranger" and "nonstranger" assaults is not that important. Persons who attack strangers or who commit felony-related murders also assault and kill their families, friends, neighbors, and acquaintances. Men who externalize their aggressive natures outside the home also do so inside; family violence is simply a continuing pattern of violent interaction. (Men who internalize their aggressive natures tend to commit suicide and there is frequently an inverse relationship between homicide and suicide rates between different cultures. The Japanese and northern and eastern Europeans internalize their aggression into very high suicide rates combined with low rates of reported criminal homicides. White males have a suicide rate more that twice their homicide rate while black males have a homicide rate more that five times their suicide rate.)

The fact that stranger/nonstranger distinctions are not that significant is closely tied to what may be the most important factor related to assault and criminal homicide: family abuse. Domestic violence rarely involves weapons of any kind, but it teaches children to become violent themselves at home, in school, among their peers, and as they become adults. If they get away with aggressive behavior at school, they learn to repeat it. Assaultive juvenile delinquents are more likely to inflict injury in such crimes as robbery in later years.

The family violence associated with later assaultive behavior frequently involves a broken home, with severe parents or guardians, a dominant mother with a father either absent or rejecting his offspring, lack of family cohesiveness, and a pattern of aggressive behavior by the child by the time he or she reaches 8-10 years of age. Since physical scars--whether from birth defects or later injuries--are associated with assaultive behavior, those which develop as a result of child abuse may be more likely than nonscarring abuse to lead to later criminality.

Other predictors of assaultive violence include other deviant behavior, such as drinking, drugs, sexual promiscuity, smoking, gambling, an unstable job record, and peers. In addition, there is some evidence from studies of separated twins that genetics may also play a role. Other possible neuropsychological and neurophysiological factors require much more research, as does the whole question of the extent to which assaultive violence is taught, either in the homes and schools or by the entertainment media. Interestingly, a survey of felons found them less likely to have played with toy guns as children than college students (Wright and Rossi 1986).

Certainly, however, the importance of violence in the home is well established, and the problem is finding constitutional and effective ways to reduce domestic violence, which is estimated to involve eight million spouses and children annually, involving up to 1.5 million injuries and nearly a million hospital visits. In addition to the criminal violence, and the future behavior it teaches, family abuse may also be a major factor in victim-precipitated assaults and homicides--an undesirable but sometimes socially acceptable solution to the problem of family violence.

Whatever the causes or cures for family violence, weapons use plays almost no role in such violence, and efforts to emphasize certain weapons could be expected to do more

harm than good, since such efforts would distract public-health professionals and others from seeking more effective explanations and cures. There is no evidence that firearm or knife availability is related to higher levels of assault or homicide, either within or outside the family. And there is considerable evidence that gun laws, aimed at reducing levels of firearm availability, fail to reduce either availability among criminals or the levels of assault and homicide. There is some question, indeed, as to whether restrictive gun laws reduce much the levels of gun ownership among nonviolent members of the community. In general, nationally and internationally, levels of gun ownership are established by sociological, cultural, and historical factors rather than by laws aimed at changing those levels after they have been established (Tonso 1982).

Criminological studies of restrictive gun laws and those relating estimates of gun availability to various violent crimes, fail to show any relationship between restrictive gun laws or gun availability and either criminal assault or homicide (Kates 1984; Cook in Wolfgang and Weiner 1982; Kleck 1986). Nor is there credible evidence that firearms spur aggressive behavior; the few studies on the subject suggest that result only (a) among persons not personally familiar with firearms and (b) when the firearm is both inaccessible to the subject of the psychological experiment and is combined with other factors which may spur aggression. Similarly, there is no evidence to support the popular assertion that the availability or nonavailability of a firearm determines whether an assault becomes a homicide. It may be a strongly held belief among many individuals, including some public-health professionals, but it is merely an assertion at this stage of research. Interestingly, where firearms are most widely available (in rural areas of the United States) not only are assaults relatively infrequent (which might support the hypothesis that gun availability deters assault by producing a fear of escalation), but those assaults which do occur are significantly less likely to involve firearms than in big cities, where households are only half as likely to possess handguns or other firearms.

Much criminological research is hampered by inadequate data bases, so that, for example, it is virtually impossible to have any clear knowledge of the types of firearms used in firearm assaults, or the types of knives in knife assaults. Indeed, even homicide data are weak regarding anything beyond a hint at a handgun, rifle, and shotgun distinction--and those data are further weakened by the lack of information on the circumstances of homicide and the inclusion of noncriminal self-defense killings in the "murder and nonnegligent manslaughter" category.

Unfortunately, although public-health research is in a position to at least encourage better collections of homicide data from medical examiners, for the most part, to date, such research has ignored the weaknesses of the data. And public-health research, to date, has failed to emphasize those aspects of assault and homicide most subject to professional study by persons with medical backgrounds and least capable of study by criminologists, such as the psychological, nutritional, genetic, and related biomedical aspects of assaultive personalities. Repeating the work of criminologists with fewer concerns about accuracy of data is a waste of scarce research resources.

In their research, public-health and criminological professionals should be more concerned than they have been to date about the rights of the individuals. This indifference

has been a greater problem among public-health specialists than among criminologists, who at least recognize that laws are not self-enforcing and that people are reluctant to serve as guinea pigs for experiments in social improvement. Privacy rights may interfere with many proposals for mandating or prohibiting behavior in the home, including the possession of certain objects and the restriction on certain activities. Other constitutional protections may limit public-health experiments which would limit freedoms of expression and firearms possession.

In addition, researchers who wish to influence policy must keep in mind psychological effects of certain government activities. The quality of life may require certain freedom from government. Little research has yet been done on the psychological benefits which accrue from certain activities even if there is no injury or death to evaluate, including the psychological benefits from feeling safer with a firearm in the home and from lack of hostility between government representatives and ordinary citizens which results when the government regulates in ways which are unacceptable to large numbers of citizens. (It is interesting that some of the most regulated societies--Scandinavia, Eastern Europe, and Japan--also have disproportionately high suicide rates. Whether it is significant as well remains to be studied.) Because it fails to take psychological factors into account, the epidemiological model may be inappropriate for studying assault and homicide.

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Violence as a Health Problem: The Example of Child Abuse and Family Violence: The Alcohol Connection

Jerry P. Flanzer

When we refer to family violence as a public health problem, we are immediately concerned with 1) the *prevalent* incidence and morbidity rates associated with family violence; 2) the effect of family violence in detracting from the *quality of life* in the United States (including costs to society); and 3), the *risk factors* which may serve as indicators to help prevent and/or decrease family violence.

Family violence is an umbrella term for an array of violent, aggressive acts by one or more family members against one or more members of the same family. Child abuse and neglect, including child sexual abuse, is the most researched form of family violence. Spousal violence (domestic violence) is quickly gaining as a "hot" research topic, while elder abuse and sibling abuse still lag behind. My talk will focus on the children but in doing a full examination of any component of family violence one quickly realizes the connections of each of these family violence parts. Thus, in looking closely at child abuse, one finds spouse abuse in many of the same families, or one finds that the abused child grows up to be a spouse abuser and perhaps an abused elder a generation or two later. Statistics for all forms of family violence are not being systematically taken, nor are the developing data banks linked, so that we do not know if we are counting the same families or different ones for each incident of spouse abuse, child abuse, etc. We do have some inkling of rates for each form of family violence exclusive of the others. Thus, we have Strauss et al. (1980) reporting 1.8 million spouse abuse cases a year and Chiles (1980) 100,000 elderly abuse cases per year. But I am here to focus on child abuse.

Prevalence

Prevalence rates of child abuse and neglect have been underestimated. Known prevalence rates have been established through surveys of official reports of abuse and a limited number of local and national random samples. Most notably, the 1979 National Incidence Study conducted by the National Center on Child Abuse and Neglect (Executive Summary, 1982) reported 652,000 maltreated children (1.05 percent of the child population). Of these, 207,600 (34 percent) were physically assaulted, and 44,700 (7 percent) were sexually abused. The American Humane Society (1982) reported 788,844 abuse and neglect reports in 1980, almost four times the NCCAN survey amount. Clearly these findings are limited by different state agency definitions of what behaviors constitute abuse and the underreporting of child abuse in general (Gelles and Cornell 1980). In addition, most states base their reports around one child in the family, failing to tally multiple family targets.

Strauss, Gelles, and Steinmetz's (1980) national representative sample of 2,143 families attempted to deal with these limitations, using only severe violence as an index of abuse in this Conflict Tactics Scale. They estimated that 3.6 percent of American children

ages 3 to 17 are abused each year. Even this study underreported, for four reasons: 1) the researchers focused primarily on physical abuse, not looking closely at emotional abuse and severe neglect; 2) they did not consider the high-risk child of 0 to 2 years; 3) data were collected on two-parent families only, although single-parent families appear to be at higher risk; and 4) data on violence used by one parent toward the child were collected, leaving out the possibility of both parents as perpetrators. The consensus is that all the above figures are too low, and that child abuse and neglect have reached epidemic proportions in the U.S.

Effect on Quality of Life

Child abuse, the most researched form of family violence, has been linked to a host of maladaptive behaviors. It has been associated with and has been seen as a precursor to the development of juvenile delinquency, adult criminality (Brown 1982; McCord 1983), legal difficulties, suicide attempts, and self-inflicted injury. Abused children have been shown to have decreased memory and verbal skills, lower self-esteem, and poorer academic performance (Friedrich et al. 1983; Martin and Beezley 1977). An unusually large number of sexually abused children have been found among clients of psychotherapists (Herman and Hirschman 1977; Swift 1977), to be rape victims (Miller et al 1978), and to be prostitutes (James and Meyerding 1977; Shilbert and Pines 1981). Sexual victimization of children has been found to be related to adult sexual dysfunctions (MacVicar 1979; McGuire and Wagner 1978; Meiselman 1978; Westermeyer 1978), promiscuity (McCary 1979), adolescent pregnancy (Herman and Hirschman 1981), depression (Bernstein 1979), intense guilt (Brady 1979), and marital difficulties (Herman and Hirschman 1981). And the list goes on--especially when delayed, long-term effects are taken into account. The economic costs to society in lost productivity, in mental health services, and in the more direct child protection and other social services is clearly in the billions of dollars.

The National Incidence Study presented some other interesting findings on income, race, and geographical factors of maltreated children (Executive Summary, 1982).

1. Maltreated children can be found in all income groups.
2. Children from low-income families are much more likely to suffer maltreatment than are children from high-income families.
3. The incidence rates for blacks and for whites are almost identical.
4. For middle- and upper-income families, incidence rates for nonwhite children are virtually identical [to] those for white children.
5. For lower-income families, incidence rates for white children are substantially higher than those for nonwhite children in all categories of maltreatment with the exception of educational neglect.
6. For each major form of maltreatment, incidence rates for white children are much higher in lower-income families than in higher-income families.
7. For nonwhite children, neglect incidence rates are much higher in lower-income families than in higher-income families. In contrast, abuse incidence rates are close to constant, at a relatively low level, across income levels for nonwhite children.

8. The incidence rate for sexual abuse is higher in rural counties than elsewhere.
9. The incidence rate for educational neglect is higher in urban counties.
10. The incidence rate for emotional neglect is higher in suburban counties.

The most extreme form of child abuse is death. Many early childhood deaths may be misdiagnosed. The New York City Mayor's Task Force on Child Abuse and Neglect recently conducted a preliminary study on child fatalities. The sample was taken from death certificates of children under six, who died during the first six months of 1980, whose deaths were listed as homicide, accident, malnutrition, exposure, and infant sudden death syndrome.

Of the 97 cases reviewed, 45 were determined to be the result of abuse or neglect. Twenty four were possible cases of abuse or neglect but the circumstances were unclear. Of the 45, abuse alone accounted for slightly less than half (47 percent) of the deaths, and neglect alone accounted for 44 percent.

Of great policy importance is that almost half of the 97 families involved had been previously reported for suspected child abuse and neglect; 62 percent of the families had been known to another social agency or hospital before the child died (St. Denis et al.).

Behavior Indicators and Risk Factors

Repeated clinical observations of the behaviors of the abusers and victims have led to a consensus of behavioral sets. Universally, all abusers, whether hitters or drinkers, project blame onto others. "It's not my fault that ...," "She deserved that ..." Universally, all abusers tend to be jealous and possessive of their targeted victims. The slightest suspicion of a spouse's relationship with another, for example, brings tirades and recriminations. Often, the abuser expects the child to behave like his/her parent, or expects the spouse to take care of everything. Role expectations are impossible to meet. If you question the abuser about the critical incident, you find that he/she doesn't always remember the details and may even "black out" the incident altogether. Nevertheless, the abuser is not abusive all the time. In fact, he/she might be otherwise a "superior citizen."

Victims tend to be socially isolated, ashamed to show their scars, not willing to expose their plight to others. Part of this social isolation is caused by the victim's internalization of the blame. The victim agrees with the abuser. "I deserve it." "I'm no good!" Invariably the victim believes strongly in family loyalty. One does not "rat" on a family member. Family secrets are guarded to the utmost. One maintains the family integrity at all costs (Flanzer 1981).

Douglas Besharov (1984) has defined some behavioral indicators used to assess signs of child sexual abuse:

1. Unwillingness to disrobe in the presence of others (e.g. unwillingness to change for gym class)

2. Excessive fear of being approached or touched by persons of the opposite sex

3. Fear of going home

4. Running away from home
5. Adolescent prostitution
6. Sexual behavior or references that are bizarre or unusual for the child's age
7. Sexual knowledge that is too sophisticated for the child's age
8. Seductiveness which is not age appropriate
9. Behavior that is withdrawn, infantile, or filled with fantasy (the child may even appear to be retarded)
10. Venereal disease in oral, anal, and urogenital areas (especially in pubescent children)
11. Unusual vaginal or urethral discharge
12. Repeated cystitis, especially in prepubescent girls
13. Pregnancy, especially in early adolescence

Five great risk factors frequently appear in the background of child abuse and neglect studies. The "more" of these factors appears to correlate with "more" child abuse and neglect: 1) the abuse itself, 2) poverty, 3) lack of empowerment, 4) isolation, and 5) alcoholism/substance abuse.

The *abuse* factor, the intergenerational risk to coming generations of continuing physical, emotional, and sexual abuse, is clear, as scores of perpetrators turn out to have been victims in their childhood. In a sense, previous child abuse itself is the greatest risk indicator (Garbarino 1980; Summit and Kryso 1978). The *poverty* factor indicates that children in poverty also appear to be at greater risk to be abused and neglected, as the frustration of parenting itself, the lack of resources and networks, inadequate housing, and poor medical care handicap the parents, who cannot protect and provide for their children. Delayed long-term effects include inadequate parenting skills and fears of intimacy for the now-adult victims.

Powerlessness equals the inability to manage emotions, skills, knowledge, and/or materials-resources so that effective performance of valued social roles will lead to personal gratifications. Empowerment is the reversing of powerlessness: empowerment problems may be agency-based. For many families child abuse and neglect in particular appears to be correlated with the lack of empowerment brought on by societal and institutional blocks. *Social isolation* is a factor that appears to influence both child abuse and neglect. Polanski et al. (1985) conducted a study to test the hypothesis that

> as compared with non-neglectful parents in comparable life circumstances, neglectful mothers experience and will express more feelings of loneliness; parents in neglectful families are more socially isolated in general; children in

> neglectful families are also more socially isolated; neglectful families live in less supportive environments; and the exclusion of neglectful parents from helping networks is due in part to their being assessed as unlikely to reciprocate help.

Neglectful families live in neighborhoods that are generally nonsupportive (Polanski & Gaudin 1983). Parents who maltreat children prefer to solve problems on their own, have few relationships outside the home, are likely to discourage outside involvements on the part of their children, and they have a life-long history of avoiding activities that would bring them into contact with other adults. Social isolation is an indicator of potential trouble and often reflects a life-long pattern of estrangement (Garbarino & Stocking 1980).

Finally, on the *alcoholism/substance abuse* factor, an important risk factor/indicator appears to be the presence of substance-abuse in the family, alcoholism in particular (since 95 percent of the substance-abuse problems in the United States continue to be alcoholism). What has only been recently taken seriously in research and clinical studies is the now-obvious link between alcoholism/substance abuse and child abuse/family violence. We have known for some time about the clinical similarity between alcoholic families and child-abusing families. Children growing up in violent homes evidence many of the same symptoms as children growing up in alcoholic homes. Clinicians have been referring to similar clinical portraits, of abusive triangles, of secrets and isolation, of stressed relationships, of failing finances, and of hopelessness (Flanzer 1981, 1982, 1986). Children of alcoholic homes appear to have the same litany of relationships to maladaptive behaviors as child abuse victims, including juvenile delinquency, low self-esteem, suicide attempts, overrepresentation among clients of psychotherapists, sexual dysfunctions, and marital difficulties, as well as huge economic costs to society (Berry 1977; Edwards 1982; Polch et al. 1981).

Do we dare ask if these are essentially the same families?! Surely not, we think, for we realize that there are alcoholic families in which no abuse is occurring and there are abusing families without a trace of alcoholism; but as we begin to look at a wider definition of alcoholism and include not only the perpetrator or drinker, but all family members; as we pay attention to the interacting effect of different drinking levels of family members with abuse; as we pay attention to the timing of relationship between alcohol intake and abuse, we begin to realize the enormity of the link. Could this alcohol link be involved in the majority of abuse cases? Could there even be a causal relationship?

Proving the Alcohol-Child Abuse Causal Relationship

In trying to prove a causal relationship, three properties must be demonstrated (Denizen 1980, p. 213).

> (1) *Association*: Proof of a significant association or correlation of the key variable must be shown. The researcher must show that the causal variables in his system produced variations in his dependent variable.

(2)*Time*: A clear temporal relationship, wherein one factor precedes the other, must be shown. The researcher must show that the causal variable occurs before his dependent variable.

(3) *Intervening Variables*: An explanation of the relationship of intervening factors as catalysts or products of a consistent link of the key variable must be shown. The researcher must show that his causal systems are not spurious--not counting on other variables.

Alcohol and Child Abuse Neglect Association

Alcoholism and child abuse/neglect have been shown to appear together in a host of studies and clinical reviews. Studies of alcoholic families have shown varying degrees of child-abuse behavior; studies of child-abusing families have similarly shown a varying rate of alcoholism among family members. A limited number of nonclinical sampling studies, i.e., "normal families," have been surveyed to show both abuses in their history. Although these studies all show associational findings, only a few show correlational findings; when one variable increases/decreases, so does the other.

Methodological and definitional issues included in the study and the degree or level of alcoholic and child-abuse behavior definitely influence the findings and make cross comparisons difficult. The correlations increase if we include all family members' drinking patterns and not just the perpetrator's. Samples of incestuous fathers have been shown to have a range from 20 to 25 percent (Meiselman 1978; Gebhard 1965) to 50 percent (Virkkunen 1974) alcoholism rate. Samples of perpetrators of physical abuse range from an alcoholism rate of 23 percent (Black and Mayer 1977) to 42 and 65 percent (Behling 1971 and 1979). Direct positive correlations--the greater amount of alcohol abuse correlated with a greater severity of child abuse and neglect-- have been found by Spieker and Mousakitis (1977) in a DWI sample and Flanzer (1980) in an adolescent abuse sample. Both of these studies noted that many of the most severe drinkers may no longer be involved with family violence for they have lost their families, while this may be the target of attackers in their stupor. Thus a curvilinear relationship between levels of abuse may exist. Downs et al. (1986) shows us that having an alcoholic father might be the reason behind sexual abuse by a significant other, delinking alcoholism from a direct cause to a secondary cause speculation.

Timing of the Double Abuse

Two timing issues need to be addressed: first, was there any drinking around the abusive act: and second, is there any pattern connecting drinking and abuse over long periods of time, particularly between early childhood and parenthood. Thus, did the drinking occur "before," "during," "after," "instead of," or was there "no relationship" of drinking timing to the abuse incident?

Several researchers report timing drinking relationship around the abusive event. On drinking during the abusive event, for example, Nau (1967) found 57 percent of the male abusers and 42 percent of the female abusers to have been intoxicated during the

abusive incident in his sample; Glazier (1971) and Gil (1973) found 13 percent of this abusing sample to be intoxicated during the event. Flanzer (1982) found nearly half of his adolescent abusing parents to be drinking instead of hitting their child, while most of the others were drinking after the abusive event. The question of a relationship between the two abuses over a long period of time helps us realize that a delayed or continuous effect may be occurring over years, among families at different places of the life cycle and between generations.

A long list of researchers reported an intergenerational finding wherein an abused child grew up to be an alcoholic adult (Behling 1971, 88 percent of alcohol sample; Black and Meyer 1977, 47 percent of sample; Kelly et al. 1985; Covington 1986; Lundy 1986). Miller et al. (1986) have reported alcoholic women tend to have been sexually abused as children over a longer period of time than the nonalcoholic women who reported childhood sexual abuse. A similar list of researchers found being raised in an alcoholic home was linked to being a perpetrator of child abuse (Familio et al. 1986; Behling 1979). So each abuse confusingly appears to intergenerationally precede the other abuse.

Intervening Factors Around the Double Abuse

A number of psychosocial variables closely associate with both child abuse and alcoholism. The stressors include first the risk factors mentioned earlier--poverty, lack of empowerment, and isolation--all of which are environmentally oriented. Second are a number of familial psychosocial stressors, such as chaotic, underinvolved/overinvolved family systems (Minuchin, 1979), negative parental verbal interaction (Downs 1986), parental psychosis, and mental retardation. Clearly, intense ecological studies of the abusing family system with appropriate multivariate (path and cluster) analysis will be needed to determine which causal systems are correct and not spurious.

In summary, child abuse and neglect remains an epidemic public-health problem. It must be seen and studied as part of a family violence system. Studies focusing on causal models are needed. This author urges a careful look at the alcohol connection to family violence as a priority concern.

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The Emergency Medical Response to Violent Crime Victims

Roy Allen

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Introduction

In 1958, Marvin Wolfgang speculated that emergency medical care plays a vital role in determining the lethal outcome of violent assault. Several years later Pittman and Handy (1964) examined the patterns of aggravated assault and found few differences from those of homicide. They too speculated that the speed of the ambulance may prevent many lethal violent assaults. Speculation has continued (Fisher 1976; Hawkins 1983; Pokorny 1965; Rose 1979; Vinson 1974; Wilson 1975). However few attempts have been made to examine the topic. Barlow (1983) examined response times for violent assaultive crime and found that lethality and ambulance response time are not related in a simple linear fashion.

In the current study, EMTS ambulance data, offense data, and injury data were collected on a systematic random sample of violent crime victims. It represents one of the first efforts to examine victims of violent crime utilizing a medically acceptable measure of injury severity.

The findings of the study are presented below. Since the topic is somewhat new to the field of criminology, the focus here is on the descriptive features. In addition, however, findings from some preliminary correlational analyses are also presented.

Methodology

The basic unit of analysis in this study is the individual violent crime victim injured severely enough to require treatment at a major urban general hospital's level I trauma center, as well as the performance of one or more in-patient surgical procedures. The setting for this study is Houston, Texas. A systematic random sample (n=215) was drawn from the weekly surgical service reports of the Department of Surgery at Ben Taub General Hospital for the period January 1, 1982, through May 15, 1982. Ben Taub General Hospital's trauma center receives over 350 patients a day and is nationally recognized for the treatment of penetrating injuries. Of the more than 2,000 major trauma cases admitted to the Emergency Surgical Service each year, over 85 percent result from penetrating injuries from gunshot and stab wounds. In 1982 Ben Taub trauma center treated 2,042 gunshot-wound victims, 1,477 victims of stab wounds, and 2,353 blunt-assault victims. Forty percent (n=2,366) of these victims were admitted and/or received surgery (Allen 1986a).

There are a number of reasons for not utilizing a population-based sample in the present study. First, since physical injuries to victims of crime can result from a wide variety of criminally violent activities and can fall into one of several crime categories (e.g., homicide, aggravated assault, sexual abuse, etc.) (Block 1977), and since most victims of

crime do not sustain a physical injury severe enough to require emergency medical attention, utilizing police offense data would require the use of an extremely large, stratified sample. Stratified samples assume a fair degree of knowledge about the population, a characteristic not found in the present instance. Secondly, victimization studies indicate that over 50 percent of violent crimes are unreported to police (USDJ 1983), although the presence of physical injury seems to influence reporting behavior (Skogan and Block 1983). Hence, utilizing official police data omits many injured victims from potential analysis. Thirdly, a population-based sample would require data collection from a large number of receiving hospitals, clinics, and private physicians. The benefits of a population-based study would be jeopardized if and when participation was not obtained from a sizable fraction of the receiving institutions. Finally, since the benefits of using hospital-based data for a criminological study were unknown, the decision to forego a population-based study was made.

There were three sources of data in the present study: Ben Taub General Hospital Trauma Center and Department of Surgery, Houston's Emergency Medical and Trauma Services Department (EMTS), and the Houston Police Department (HPD). Data from Ben Taub General Hospital included injury data, date of surgery, mortality, method of arrival at the hospital, date and time of arrival, and EMTS ambulance number. These data were linked to EMTS records. EMTS data included times of dispatch, arrival at the scene, departure from the scene, and arrival at the hospital. Also, data were collected concerning patient care procedures, patient medical assessment, and whether or not the police were at the scene. Finally, data were linked to HPD offense/incidence reports. These data included spatial and temporal characteristics of the offense, victim and offender characteristics, and weapon characteristics. Unfortunately, data were not available from private and out-of-city ambulance services.

In the current study the injury data collected from Ben Taub General Hospital were used to determine the severity of each injury inflicted. For this purpose the Abbreviated Injury Scale (AIS; 1980 ed.) was used. The AIS is a lesion-specific anatomical injury severity assessment procedure developed originally for use in evaluating the severity of injuries resulting from automobile accidents. Its utility for the present purposes has been discussed elsewhere (Allen 1986b). Since many victims of violent crime are the recipients of multiple injuries, the overall severity of injuries was determined using the Injury Severity Score (ISS). The ISS was developed by Baker, et al. (1974) and represents a methodological alteration of the AIS. The resulting scale represents the sum of squares for the single most severe AIS value in up to three body regions.

Findings

Injury data were obtained on all 215 subjects in the study. Of the 153 (71.2 percent) subjects who were serviced by the Houston EMTS Department, records were located on 142 (92 percent). In addition, HPD offense reports were located for 140 (65.1 percent) of the sample subjects. Analysis of this latter finding indicates that most of the cases where HPD offense reports could not be found arrived at the hospital by private or out-of-city ambulances suggesting origin in another jurisdiction.

The Victim

The victims' injuries ranged in severity from ISS=1 to ISS=50. The median score was 16, with a modal value of 25 (Mean=17.9; S.D.=10.2). Twenty- three victims (10.7 percent) died during or sometime after emergency surgery was performed. In 93.6 percent of the cases the injured party was the complainant while 6.4 percent were the suspects. In the vast majority of the cases (85 percent) there was only one victim. In 10 percent of the cases there were two victims, and in 5 percent there were three or more. Over three-fourths (78.7 percent) of the victims were between the ages of 17 and 34 years of age. Blacks comprised 43.7 percent of the victims, while 32.4 percent were Hispanic and 23 percent were white. Most victims were male (88.8 percent), while only 24 (11.2 percent) were female. In 37 percent of the cases the victim and offender were strangers. In the majority (52.1 percent) of the instances, however, they were acquainted, and in 10.9 percent they were related.

The Assailant

The assailant ranged in age from 9 years to 70 years (Mean=28.3; S.D.=10.6). Slightly over half (52.5 percent) were black, 25.4 percent were Hispanic, and 19.7 were white. Most were male (88.6 percent), while only 14 (11.4 percent) were female. In 71.3 percent of the cases there was only one offender, although in 15.5 percent there were 2 offenders, and in 12.4 percent there were three or more. In almost two-thirds of the cases the offenders were spurred to violence during an argument, while in 28.6 percent of the cases the injury occurred during the commission of another felony by the offender, two-thirds of which were robbery. Well over half (59.3 percent) of the offenders were charged with aggravated assault, 15.7 percent with murder, and 12.1 percent with attempted murder.

The Offense

The victim and/or offender's residence served as the location for 35 percent of the offenses, while a bar/drinking establishment was the site in 20 percent of the cases. A public or private street/parking lot was the location for 27.2 percent of the offenses.

Almost two-thirds (62.1 percent) of the offenses occurred on the weekend (Friday through Sunday) and 37.9 percent took place on a weekday. Over half (57 percent) of the violent injuries were inflicted between 9:01 p.m. and 3:00 a.m., while 24.6 percent of the victims were injured in the late afternoon or early evening (3:01 p.m. through 9:00 p.m.).

Almost two-thirds (63.7 percent) of the victims were injured by firearms and 36.3 percent were victims of stab wounds. In 34.3 percent of the offenses no witnesses/third parties were present. In 29.9 percent of the cases one witness/third party was present. In the remaining cases (35.8 percent) between two and twelve individuals were witnesses/third parities to the offense.

The Emergency Medical Response

Victims arrived at the hospital by a variety of methods. EMTS ambulances were utilized in the vast majority of the cases (74.6 percent), while private vehicles were used by 13.7 percent of the victims. Slightly less (9.8 percent) arrived at the hospital in a private ambulance, while only 1.5 percent were transported by an out-of-city ambulance.

EMTS ambulance response time to the scene ranged from two to twenty minutes. The average (mean) response time was 5.7 minutes (S.D.=2.9). Time spent at the scene by EMTS personnel varied widely from two minutes to forty minutes. The average (mean) time at the scene was 15.4 minutes (S.D.=7.13). Finally, the time spent in transit from the scene to the hospital varied even more widely, from one minute to fifty-three minutes. The average transport time was 11.2 minutes (S.D.=6.1 minutes). The total emergency medical response time from dispatch to hospital arrival ranged from 12 to 78 minutes with a mean time of 31.7 minutes (S.D.=10.4 minutes).

A number of EMTS services were provided to these victims of violent crime. Almost three-fourths of the victims were given intravenous (IV) treatment (IV therapy was attempted but failed in 6.6 percent of the cases). Telemetry was utilized for two-thirds of the victims. Over half (54.7 percent) of the victims received wound bandaging, while procedures to control bleeding were administered to 41.6 percent of the victims. Thirty-one percent of the victims were provided military antishock trousers and 28.5 percent of the victims were administered therapeutic drugs. Twelve victims (8.8 percent) were provided transportation only. Other EMTS patient services included extrication (2.9 percent), suction (2.9 percent), restraint (2.2 percent), splinting (2.2 percent), spinal immobilization (1.5 percent), and resuscitation (0.7 percent). The number of EMTS services provided each patient ranged from one to six and averaged (mean) 2.7 services each (S.D.=1.8).

A variety of patient medical assessments was made by EMTS personnel. Over half of the patients were assessed as hemorrhaging (51.5 percent), while 16.2 percent were in shock and 16.2 percent were experiencing dizziness. Shortness of breath was experienced by 10.3 percent of the patients and 11.8 percent were experiencing abdominal pain.

Data from the Houston EMTS Department also included information about whether or not the police were on the scene while EMTS personnel were present. In almost two-thirds of the cases (62.3 percent) the police were present.

Additional Analysis

Several variables were selected for additional analysis and comparison with the injury severity score. Five variables correlated with ISS: number of EMTS procedures (0.159), victim age (-0.133), victim mortality (0.406), type of weapon used (0.267), and number of witnesses/third parties present (0.337).

Most of the results of this analysis are as expected. The number of EMTS procedures should be somewhat related to injury severity. In addition, victim mortality and type of weapon were expected to be significantly related to injury severity. However, the interpretations of two findings are not so evident. Victim age was negatively correlated with ISS indicating that younger offenders are somewhat more severely injured than older offenders. The injury epidemiology literature suggests that younger people are more often

injured than older individuals. The explanation for this phenomenon typically focuses on differences in life-style and risk-taking behavior on the part of younger individuals. Explanations of the present finding should probably take a similar approach.

The presence of witnesses/third parties was positively related to ISS: the greater the number of witnesses/third parties the more severe the injury. Barlow (1983) suggested that the presence of witnesses may serve to expedite the call for assistance, while Luckenbill (1977) and Felson, et al. (1984) found that witnesses/third parties were likely to be supportive of the offender and/or the violence. These findings are supported by the present study. However, some caution should be exercised in drawing a firm conclusion. In many large urban police departments when a victim sustains a serious life-threatening injury, investigation of the case proceeds in a manner identical to the homicide case, since to initiate the homicide investigation only after a victim succumbs to the injuries would result in the potential loss of valuable information. The nature of a homicide investigation may often result in more thorough surveys of likely witnesses. Hence the relationship between witnesses and ISS may be the result of more thorough investigation of cases with severely injured victims.

No statistically significant relationships were found between mortality and number of EMTS procedures, EMTS time at the scene, transport time, total EMTS service time, and age of the victims. However, these represent only preliminary results. Although the coefficients are small and not statistically significant, they are in the expected direction.

Conclusions and Summary

The results of this study indicate that the emergency medical response to victims of violent crime involves much more than "scoop and run." Response times to the scene were rapid with little variation. However, the time spent at the scene varied widely. Much of this can be explained by the number of procedures performed, the severity of the injuries treated, and the clinical condition of the victim. Overall response, treatment, and transport time was relatively quick, averaging approximately 30 minutes.

Several variables were related to injury severity. These included the number of EMTS procedures performed, victim age, victim mortality, weapon, and the presence of witnesses/third parties. Outside of injury severity, no factors were found to be significantly related to mortality, though a final conclusion must await additional analysis.

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Spouse Abuse

Anne Helton, Elizabeth Anderson and Judith McFarlane

[Anne Helton's biography appears in appendix D. Elizabeth Anderson is Assistant Dean, and Judith McFarlane is Associate Professor, at the College of Nursing, Texas Woman's University, Houston. Anderson and McFarlane are co-principal investigators, March of Dimes Professional Education Grant.]

Introduction

Pregnant women feel uncertainty and insecurity about the child throughout their pregnancy (Rubin 1984). In the first trimester there is the uncertainty about the pregnancy itself an a sense of vulnerability to loss by mishap, miscarriage, or even bad luck. The second trimester provides the woman with feedback from the fetus within, but she still may feel the sense of vulnerability, which increases markedly as she approaches labor and delivery. The pregnant woman attempts to reduce this uncertainty by gaining knowledge from professionals, family, and support persons. She many spend nine months searching for models and images of her wished-for child, as well as models to guide her impending labor and delivery experience. For women who are threatened, battered, and abused during pregnancy the fears and uncertainities about pregnancy outcome, as well as fears for their own lives, are compounded.

Battering of women is an underreported crime, associated with health consequences, that has legal, social, and cultural roots in patriarchal systems. The causes of battering range from psychopathology to learned sociocultural acceptable behavior, to alcohol or drug abuse, to abuse as a child, to oppression of women in general.

Although battering includes four types of interpersonal violence--physical, sexual, property, and psychological--in this study, battering was limited to physical assault. The problem of battering during pregnancy has been acknowledged in the literature on violence for at least 10 years (Gelles 1975), and yet it remains largely ignored by health-care providers. Campbell and Humphries (1984) stated that battering during pregnancy may be more common than diabetes in pregnancy or malpositioned placenta, and a great deal of time and money are spent screening for diabetes and malpositioned placenta problems during pregnancy. Further, women's bio-psycho-social changes during pregnancy are often inferred as causes of battering.

Another study reviewing charts of 2,676 women treated in an emergency department found 21 percent of the women's injuries were positive, probable, or suggestive of battering. The battered women were more likely to have been pregnant or to have miscarried than the nonbattered women. Literature on battered women frequently describes violence inflicted on pregnant women. Interviews with 80 families on the incidence and types of violence between husbands and wives found 25 percent of the battered women reporting battering during pregnancy. Reports from a shelter for battered women found 42 percent of 542 women entering the shelter to have experienced battering

during pregnancy. The pregnant battered women reported blows to the abdomen, injuries to the breasts and genitals, and sexual assault. In a study of 400 battered women, 59 percent reported battering during the first pregnancy, 63 percent during the second, and 55 percent during the third pregnancy. A subsequent study interviewed 270 battered women and found that 44 percent has been abused during pregnancy. Of those battered during pregnancy, 18 percent reported miscarriage following the abuse. Further, men who batter pregnant women were found to be three times as likely to display violent behavior outside the home.

Most information on battering during pregnancy has been obtained from convenience samples of battered women in shelters, emergency centers, or counseling centers. Data are usually elicited in a crisis atmosphere and no standard assessment or reporting process for battering exists. Despite the fact that a large percentage of battered women require medical treatment, battering has been viewed as a social or private family matter and not a health concern. To date, only one study has examined a general population of pregnant women. The nonrandom survey examined psychological risk factors during pregnancy among 742 women in a general obstetrical clinic and identified 10.9 percent (n=81) of the pregnant women as battered. When compared to the nonbattered women, the battered women reported statistically significant more emotional problems, as well as alcohol or tobacco use; 20 percent of the battered women had attempted suicide.

To document the prevalence of battering during pregnancy and to correct the biases associated with convenience sampling and retrospective analysis, a random sample of 290 healthy pregnant women from public and private clinics in a large metropolitan area with a population exceeding 3 million were interviewed between February and September of 1985.

The Sample

All 290 pregnant women were selected from six public and two private prenatal clinics and interviewed during routine prenatal clinic appointments. The six public clinics were randomly selected from 13 prenatal clinics. The clinic served approximately 14,047 prenatal care patients in 1985. The private clinics were not randomly selected, although the clients interviewed were. The two private clinics provided prenatal care for approximately 350 women in 1985.

A total of 240 public (1.7 percent of number served) and 50 private (14.3 percent of number served) clinic clients were randomly selected and interviewed. The primary difference between public and private clients was financial status. Public clients must meet service eligibility requirements that are based on income and family size. The ethnic distribution of prenatal clients in the public clinics of the metropolitan area for the year preceding the study was as follows: white, 37 percent; black, 27 percent; Hispanic, 31 percent; and other, 5 percent. Because cluster random sampling was followed for the clinic selection, the generalizability of the results is applicable to all women using the public and private clinics in the study.

The sample of 290 mostly black, white, and Hispanic women ranged in age from 18 to 43 years. The average age of public clients when interviewed was 25 years, and the

average age of the private clients when interviewed was 28.5 years. The majority (71 percent, *n*=205) of the sample were married, 58.3 percent (*n*=169) had graduated from high school, 25.8 percent (*n*=75) reported some college, and 22.4 percent (*n*=65) were employed. The racial and ethnic distribution of the total sample was as follows: black, 22.4 percent (*n*=65); Hispanic, 43.1 percent (*n*=125); white, 32.1 percent (*n*=93); with 2.4 percent (*n*=7) American Indian or Asian. The modal month of pregnancy when interviewed was 8 months, with 80 percent of the women at least 5 months pregnant.

The instrument used to collect the data on battering during pregnancy was a 19-item interview questionnaire. Ten questions were demographic (age, marital status, education, and employment) as well as questions on gravidity and number of living children. These questions were followed by nine questions focused specifically on abuse.

Results

Of the 290 pregnant women interviewed, 15 percent (*n*=44) reported battering before the current pregnancy, 8 percent (*n*=24) reported battering during the current pregnancy, and 4 percent (*n*=11) had been threatened with abuse. Battering during pregnancy did not vary according to race and ethnicity; however, Hispanic women were more likely to be battered before pregnancy (52.3 percent) than white (27.3 percent) and black (18.2 percent).

Of the 50 pregnant women interviewed from the private clinics, 14 percent (*n*=7) had been battered before or during the current pregnancy. Of these, 57 percent (*n*=4) were battered before the current pregnancy, and 43 percent (*n*=3) were battered during the current pregnancy. Of the 240 pregnant women interviewed from public clinics, 25 percent (*n*=61) had been battered before or during the current pregnancy. Of these, 65.5 percent (*n*=40) were battered before the current pregnancy, and 34.6 percent (*n*=21) were battered during the current pregnancy.

The women battered before pregnancy were older (mean=26.5 years) than the women battered during pregnancy (mean=23.6 years). The modal month of pregnancy when interviewed was 8 months for women battered before or during pregnancy.

Of the women battered during the current pregnancy, 33 percent (*n*=8) had sought medical attention for injuries sustained. Of the 44 women battered before the current pregnancy, only 2 (5 percent) had sought medical treatment. Of the 24 women reporting battering during the current pregnancy, 29.1 percent (*n*=7) reported the battering increased following the pregnancy and 87.5 percent (*n*=21) reported abuse prior to pregnancy. Of the women battered before pregnancy, 18 percent (*n*=8) had left the abusive male compared to none of the women battered during current pregnancy. Furthermore, 19 (79 percent) of the women battered during the current pregnancy reported multiple abuse sites as compared to 13 (29.5 percent) of the women battered before pregnancy. Four women battered during pregnancy were choked compared to one woman battered before pregnancy. The predominant site of abuse reported for women battered before and during pregnancy was the face and neck area. In addition, four women were pulled by their hair, five were kicked in the vaginal area or buttocks, and three were thrown down.

Table 1
Profiles of Women Battered during Current Pregnancy and before Pregnancy

Profile of Woman Battered during Pregnancy (*n*=24)	Profile of Woman Battered before Pregnancy (*n*=44)
White (33 percent)	White (27 percent)
Black (29 percent)	Black (18 percent),
Hispanic (33 percent)	Hispanic (52 percent)
24 years or younger (mean=23.6 years)	26.5 years or older (mean=26.5 years)
Married (71 percent)	Married (66 percent)
1st or 2nd pregnancy (25-37.5 percent)	3rd pregnancy or more (68 percent)
Employed (29 percent)	Employed (18 percent)
High-school graduate (62 percent)	High-school graduate (41 percent)
Prior abuse (87.5 percent)	N/A
Battering increased/ multiple sites (79 percent)	Multiple abuse sites (29 percent)
Likely to seek medical treatment for injuries (33 percent)	Likely to seek medical treatment for injuries (5 percent)
Currently residing with abusive male partner (100 percent)	Currently residing with abusive male partner (82 percent)

Using chi-square analysis, the 68 battered women reported a statistically significant ($p \leq .05$) higher percentage of pregnancies and greater number of living children than the nonbattered women. In additon, the nonbattered women were more likely to be gravida one and the battered women were more likely to be gravida three.

Several factors distinguish the woman battered before pregnancy as compared to the woman battered during the current pregnancy. Table 1 describes the differences and provides some guidelines in the attempt to profile the woman battered during pregnancy.

The women battered *during* pregnancy were more likely to be gravida one or two as compared to the women battered before pregnancy who were more likely to be gravida three or more. In addition, the women battered before pregnancy were more likely to have three or more living children.

Eleven (4%) pregnant women answered in the affirmative to the question, "Does he threaten you with abuse?" These women expressed fear concerning threats of violence and the cycle of violence theory was explained by the investigator.

Discussion

In this study of 290 randomly selected pregnant women from public and private prenatal clinics, 8 percent reported physical battering during this current pregnancy; 15 percent reported battering prior to the present pregnancy; and 4 percent reported threatened battering. None of the women has been assessed for battering by a health-care provider or provided with community resources.

Results

Following the prevalence study, an educational program, Prevention of Battering During Pregnancy,* was initiated that focused on health professionals and students in the health professions. A 19-minute slide-tape production, an abuse assessment guide, and primary intervention strategies were presented to 841 health professionals including physicians, nurses, and social workers. Pre- and post-test scores were compared to measure a statistically significant change in knowledge following the program. Six months after the program, a survey revealed that 75 percent of the health-care providers who had participated in the program were assessing pregnant women for abuse or in the process of developing an assessment protocol. Prior to the educational program, none of the health professionals assessed pregnant women for battering.

Follow-up sessions were offered to all agencies along with a manual, *Protocol of Care for Battered Women*, that included information on current state and local laws regarding arrest policies for battering; therapy programs for batterers; and preparation of agency staff to implement a primary care program for women at risk of or experiencing battering. The protocol offered step-by-step assessment and intervention strategies including dialogue examples. A supplemental in-service program with seminar discussion and role playing was offered for practice in usage of the protocol. Agencies desiring

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consultation and assistance in establishing a protocol and evaluation system were so assisted.

To supplement the educational program and initiate education of the public, a brochure, "Are You in a Safe Relationship," was developed and distributed to health providers. The brochure offered explicit facts on battering and battering during pregnancy and described the cycle of violence and effects of battering over time on the behavior of women, children, men, and society. The brochure included a list of local resources for counseling, legal aid, emergency shelter, and physical protection. In addition, an 11"x14" poster depicting the cycle and effects of battering was offered to all health-care providers for use in client waiting areas. Each poster provided community resources on battering along with phone numbers on tear-off sheets.

For most women pregnancy is the only time that frequent, scheduled contacts are made with health-care providers. Pregnancy is an access point for the health-care provider to screen for actual or potential battering, to educate about the cycle of violence, and to provide primary intervention for the battered woman. Once educated to the scope and significance of the problem of battering during pregnancy, most health-care providers intended to assess their prenatal clients for abuse and, indeed, most were assessing six months following the program. Battering is a health problem requiring primary care for physical injuries and follow-up counseling for emotional trauma. Traditionally, battering has been viewed as a "private" problem affecting few women. Additional myths and misconceptions have impeded the health-care providers' assessment, intervention, and--most important--prevention.

Medical Costs of Violence to Taxpayers in Harris County, Texas: Pilot Study

Louis A. DeNino

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Violence generates considerable cost to society. Many of the costs are paid directly by taxpayers, such as criminal justice costs, prison costs, and monetary assistance to victims in the form of disability checks and increased welfare expenses. What we often fail to recognize is that the medical costs that violence causes are in large part borne by taxpayers as well as victims. Public hospitals see a disproportionate share of victims, and many of these are medically indigent. In addition, public outpatient clinics, rehabilitation, home health counseling, and other programs render services to victims and their families.

The research presented here is the result of a pilot study, aimed at estimating the medical costs of violence in a public hospital. This research represents a small first step in estimating the total medical costs of violence borne by taxpayers. Certainly knowledge of these costs is useful from both the perspectives of legislative action and program development to reduce violence as well as to improve planning on the part of institutions which currently deliver medical services to victims.

Cost of Illness Methodology

For more than 25 years a great deal of attention has been focused on measuring the economic costs of disease and injury. The pioneering work of Weisbrod (1961), Mushkin and Collings (1959), Klarman (1965), and many others addressed a number of important methodological issues. What are the appropriate ways for dealing with discounting, employment rates, the presence of multiple health conditions, transfer payments, and the value of household labor? All of this work laid the foundation for Rice's landmark study (1966) which presented and applied a methodology for estimating the costs of major disease categories. Cooper and Rice (1976) updated this work, and this version has become the reference point for researchers in this field. Hartunian, Smart, and Thompson (1980) investigated cancer, coronary heart disease, motor vehicle injuries, and stroke--each a leading cause of death. They followed the approach of Cooper and Rice (1976) but with two major differences: the degree of disaggregation and the accounting approach.

Cooper and Rice (1976), as well as most studies to date concerning cost of illness and specific diseases, have followed the prevalence approach in measuring cost. Hartunian et al. (1980) adopted the incidence approach, which is the approach utilized in this pilot and to be more fully actualized in our major study of medical costs of violence.

Both the prevalence and incidence approaches distinguish between direct and indirect costs. Direct costs are comprised of goods and services actually utilized in the medical treatment of the disease or injury in question and includes expenditures for emergency services, hospitalization and outpatient treatment, drugs and medical supplies,

medical equipment and appliances, home modifications, paramedical expenses, institutional care, and rehabilitation services. In addition, direct costs include administrative expenses of managing and funding medical care.

Indirect costs represent economic products--goods and services--not produced due to impairment. Frequently we distinguish between morbidity costs, which are indirect costs arising when people are too ill to work, and mortality costs, which measure the lowered economic product due to death.

The underlying rationale of the prevalence approach is that disease or injury cost should be assigned to the years they are borne versus the year in which the disease or injury was incurred. In contrast, the incidence approach assigns the stream of costs associated with a health condition to the year in which the stream starts.

Whether the prevalence or incidence methodology is more relevant depends upon how the results will be used. For decisionmakers concerned with controlling the current medical costs of absenteeism associated with any illness, the prevalence approach is preferred. For decisionmakers interested in prevention and ameliorative programs, the prevalence approach is misleading in that it focuses on the current costs of conditions that commenced in the past and that preventive programs we might undertake today cannot affect.

The annual value of a vaccination or a violence prevention program is best calculated following the incidence approach. The incidence approach allows us to calculate the present value of the stream of costs which could be averted by reducing the incidence of some disease or injury in some particular year. We are thus enabled to calculate the "pay-off" from preventive investments.

Plans for the Major Study

Data concerning the direct costs of injury due to violence are generally not available or are seriously lacking in reliability. The U.S. Department of Justice (1984) recently compiled some national figures on the medical costs attributed to violent acts, but these are of little value. The methodology employed in compiling the data was to ask victims what their total medical bills were. The responses to such a request are not very reliable and often fail to be inclusive. Also, there is a failure to differentiate between costs and charges. At the Southwest Center we are beginning a study to measure the direct costs of violent injuries in Harris County. We have chosen to focus on direct costs as these are mainly medical and health related, to capitalize on our strengths in the health-care area. Our study will employ the incidence approach and will track victims starting with EMS records to outpatient and rehabilitation services. In addition to measuring direct costs from a social perspective we will also be measuring the direct costs to taxpayers as many of these costs are incurred in public institutions or by publicly sponsored programs or by Medicaid.

In the initial phase of our work we will be selecting a sample of injured victims from the trauma center at Ben Taub General Hospital, which is a public hospital belonging to the Harris County Hospital District. The sample will be stratified to be representative of the demographic makeup of the population of victims and the type of injury: penetrating versus nonpenetrating trauma.

The victims selected will be tracked starting with EMS records, if applicable, through their hospital stays and outpatient services, including counseling and social work. When services will be required permanently or for a number of years, an estimate will be made of the present value of the future stream of costs.

Most health-care institutions have data on *charges* for services, not *costs*. We will adjust charges by using cost-to-charge ratios which we will estimate on the basis of service delivered to a subset of our sample in each of the three main categories: gunshot wounds, stabbings, and aggravated assault.

The study will attribute costs by source of payments so that taxpayer versus private costs can be distinguished. The first phase of our study will measure the annual hospital costs of violent crime in Ben Taub General Hospital, with costs borne by taxpayers identified.

The Pilot Study

The results presented today represent a very early stage of our research. The major aim of the pilot was to ascertain whether it was possible to identify the costs for violent injuries at Ben Taub, broken down by type of injury as well as sex, ethnicity, and age. Originally we had proposed selecting a small stratified sample of 50 victims drawn over a 90-day period and tracking this group for 90 days. However, time and cost limitations restricted us at this time to looking at just one month's worth of data. From my colleague Roy Allen's work (1986) using similar data to construct a severity-of-injury scale, which he presented earlier in this conference, we already know that it is possible to obtain the detailed demographic breakout we proposed. We also are confident that Ben Taub's business office can give us a breakdown of source-of-payment for in-hospital expenses. Thus for the purpose of this pilot we concerned ourselves with a consideration of the ability to estimate the in-hospital cost of treating violent injuries at Ben Taub. We were able to obtain from the patient log at Ben Taub's trauma center a complete listing of patients who came to the trauma center who had violent injury as a chief complaint during July 1986. The log contains each patient's emergency center number as well as a corresponding medical record number. Using these numbers we were able to obtain the total charges incurred by each victim at Ben Taub General Hospital. By using an overall cost-to-charge ratio of 4/5 which was obtained from Dr. Mike Bullard, administrator of Ben Taub, we were able to convert charges to costs. In the major study we will most likely estimate a specific cost-to-charge ratio for penetrating and nonpenetrating injuries separately to assure greater accuracy.

Pilot Results

Gunshot Wounds. Sixty-eight victims were injured as a result of gunshot wounds (table 1); the vast majority were male. Of these 68 patients, charges were available for 60. Total charges were $253,624, with individual charges ranging from $40 to $30,334. The average charge was $4,227; however, observation of the median and standard deviation indicates that the distribution is skewed with a broad dispersion. Adjusting the charges, we see the total and average costs are $202,899 and $3,382, respectively.

Stab Wounds. There were 120 stab-wound victims (table 2) and, again, these were mostly male. Charges were available for 109 of these. Total charges were $271,975 with individual charges ranging from $22 to $18,127. The average charge was $2,495, but again the median and standard deviation demonstrate that the distribution is skewed and broadly dispersed. Total and average costs are $217,580 and $1,996, respectively.

Aggravated Assault. Of the 128 aggravated assault victims that came to Ben Taub last July, the majority were male, but that majority was slimmer in comparison with gunshot wounds and stab wounds (table 3). Approximately 41 percent of aggravated assault injuries were incurred by females. Total charges were $53,392, ranging from $30 to $7,554. The average charge was $477, and although the median and standard deviations indicate that the distribution is skewed and dispersed, these tendencies are not as severe as they were with respect to gunshot and stab wounds. Total and average costs are $42,714 and $382, respectively.

Summary. Adding together the data for each of the previous three categories, we see that during July 1986 there were 316 violent injuries treated at Ben Taub and that males outnumber females by a ratio of 3 to 1 (table 4). There were 281 cases with charges reported, and total charges were $578,991 with total costs of $463,193. Average charges and costs were $2,060 and $1,648, respectively. Annualizing total costs with imputations for unreported charges yields a projected total cost of $6,250,633.

Social Abuse. Table 5 supplements the previous results by adding information on social abuse broken down by type. There was some overlap of patients in these categories with those reported under aggravated assault. These were adjusted for in computing the figures in table 6. There were 36 patients identified as victims of some form of social abuse. Geriatric abuse was a separate subcategory, but there were no patients reported under this heading during July 1986.

We had charges for 35 of the 36 abused victims with total charges and total costs of $8,850 and $7,080, respectively. Table 6 indicates that, including social abuse victims, there was a total of 348 patients with violent injuries in July 1986 at Ben Taub, with total charges and costs of $587,158 and $469,726, respectively. Annualizing the total cost and making imputations for unreported charges yields a total projected cost of $6,287,102.

Conclusions

The pilot study demonstrates that it is possible to use hospital records to estimate the in-hospital costs of violence. Data for July of 1986 indicate that most victims are male with women more inclined to have injuries due to aggravated assault and social abuse.

The in-hospital costs of the majority of individual patients are well below $1,000, with most being below $500. This indicates that the total cost is heavily influenced by a small number of serious cases. Thus the costs of violent injury are volatile from one time period to another as severity can fluctuate considerably.

For this very reason, we wished that we could have adjusted our finding to incorporate seasonality factors. However, it was not possible to make such adjustments at this time. Nevertheless, we believe that results presented are representative of the magnitude of hospital costs associated with violent injuries at one public hospital.

A cost of over $6 million at one county hospital is considerable. We would speculate that most of these costs are borne by taxpayers since violent injury tends to be overrepresented in the low-income and uninsured population.

When we consider that these are only in-hospital costs at one hospital and that such costs do not include the cost of outpatient, rehabilitation, and counseling expenses, we feel secure in hypothesizing that total medical costs of violence in Harris County are in the tens of millions of dollars and that a large part, if not most, of these costs are borne directly by taxpayers.

Table 1

Gunshot Wounds

	Total	Male	Female	Unknown
Number of victims	68	59	4	5
With charges reported	60			

	Total	Range	Mean	Median	Standard Deviation
Charges	$253,624	$42-$30,334	$4,227	$880	$7,215
Cost	$202,899	$3,382	$704	$5,772	

Table 2

Stab Wounds

	Total	Male	Female	Unknown
Number of victims	120	94	20	6
With charges reported	109			

	Total	Range	Mean	Median	Standard Deviation
Charges	$271,975	$22-$18,127	$2,495	$417	$4,066
Cost		$217,580	$1,996	$334	$3,253

Table 3

Aggravated Assault

	Total	Male	Female
Number of victims	128	76	52
With charges reported	112		

	Total	Range	Mean	Median	Standard Deviation
Charges	$53,392	$30-$7,554	$477	$190	$1,050
Cost	$42,714		$382	$152	$840

Table 4

Summary

	Total	Male	Female	Unknown
Number of victims	316	229	76	11
With charges reported	281			
Total charges	$578,991			
Mean	$2,060			
Total costs	$463,193			
Mean	$1,648			
Total projected costs for 1986	$6,250,633			

Table 5

Social Abuse

	Sexual	Battered Wife	Battered Child	General Abuse	Total
Number of victims	23	9	1	3	36
With charges reported	23	9	1	2	35
Total charges	$8,850				
Mean	$253				
Total costs	$7,080				
Mean	$202				

Table 6

Total and Projected Cost Including Abuse

Number of victims	348
With charges reported	312
Total charges	$587,158
Mean	$1,882
Total cost	$469,726
Mean	$1,506
Total projected cost for 1986 with abuse included	$6,287,102

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A Violence Monitoring and Surveillance System for the Southwest Region: A Research and Demonstration Project (Edited Grant Proposal Outline)

Linda Lloyd

Background

In October 1985 a two-day workshop on the topic of violence was convened in Leesburg, Virginia. Chaired by the U.S. Public Health Service Surgeon General, C. Everett Koop, it was attended by prominent leaders representing various professional disciplines as well as most regions of our country. Several major recommendations emerged from the Leesburg Violence Conference. One was to promote regional efforts in various parts of the United States to explore this pressing issue further and discuss solutions to it. Dallas leaders, together with those from Houston, San Antonio, Louisiana, Oklahoma, the military, and the American Indian population, while still in Leesburg, started planning for a conference in the Southwestern Public Health Service Region. The Southwest Regional Conference on Violence is now a reality and will be held November 6-8, 1986 in Dallas, Texas.

Widespread support for a collaborative effort addressing the increasing problem of violent behavior in our society is indicated by the extensive co-sponsoring participation for this conference, which includes the LBJ School of Public Affairs, the National Institute of Mental Health, the U.S. Public Health Service, Bureau of Health Care Delivery and Assistance, the Office of Minority Health, Department of Health and Human Services, the University of Texas Health Science Centers at Dallas and Houston, and the Department of Defense's Family Advocacy Programs.

The long-term goal of this conference is the reduction of violence and related morbidity and mortality. Because of conference planning activities and the desire to continue to share resources and solutions, the proposed project outlines the establishment of a southwest regional violence monitoring and surveillance system. The intent of the proposed project is the formation of a regional network among the health departments of five contiguous states, the primary purpose of which will be the creation of a reliable data base for monitoring and surveillance on which to make sound decisions for the future.

The Southwest Region

Five states--Arkansas, Louisiana, New Mexico, Oklahoma, and Texas--comprise the Southwest Region. Together, these states represent approximately 11 percent of the total U.S. population: more than 27 million (1985 estimate) people live in this region. More than one quarter of the residents in this region are black, Hispanic or American Indian. From 1970 to 1980, this region had a population increase of more than 23 percent; during the same time period, the population in the U.S. increased by only 11 percent. Texas is the most urbanized state of the region with 80 percent of its population living in urban areas.

Arkansas is the most rural state of the region with 48 percent of its population living in nonurban areas.

Organizational Capability

For these five states, the proposed project will serve as a catalyst in the development of a regional/state surveillance and monitoring system for fatal and nonfatal violent injuries. There is agreement that improved surveillance methods are needed by local, state, and national health agencies. Rather than compete with one another, the five states of this region agree that they should provide leadership in synthesizing and analyzing data and work together to demonstrate the usefulness of these data in influencing decisionmakers who can attack the problem of intentional injury. It is with this cooperative spirit that the proposal is submitted. With current budget constraints in each of the five states, no firm commitment for continuous state funding can be made. Every state will do what it can to see that the project continues. Should state funding not be available at the end of the one-year grant period, the results and recommendations of the project will be merged with the activities of the appropriate Injury Prevention Research Center.

The Texas Department of Health (TDH) will have administrative responsibility for the project. Linda Lloyd will serve as project director and will devote 35 percent of her time to project activities. The regional data analysis component of the project will be located within the Bureau of Epidemiology at the TDH. In 1984 the Bureau of Epidemiology created an Environmental Epidemiology Division. During the last two years, this division has been involved in several injury-related epidemiologic studies and prevention activities. In this division, documents have been prepared in the area of violence and distributed as TDH publications or submitted to professional journals.

With regards to the 1990 Health Objectives, the Texas Department of Health has been in the forefront. In Texas in 1983, more than 250 people participated in the Texas Conference on Disease Prevention and Health Promotion: 1990 Objectives. This meeting was sponsored by the Texas Department of Health, and the University of Texas Health Science Center at Houston School of Public Health and Center for Health Promotion, Research, and Development. At the initial conference, the participants working in 15 different workgroups tailored the national objectives to meet the health characteristics and needs of the Texas population.

Project Advisory Committee

A Project Advisory Committee will be convened to advise and guide regional project staff at key points in the project. The Project Advisory Committee composed of senior-level scientists will be expert in violence-injury data analysis and management and will represent federal and state public-health personnel. At a minimum there will be five scientistis including a professional epidemiologist, demographer, biostatistician, and health-policy analyst. Regional project staff will serve as the working members of the committee. Linda Lloyd, Project Director of Environmental Epidemiology for the Texas Department of Health, will serve as an ex-officio member. Dr. Ralph Frankowski,

Professor of Biometry, University of Texas School of Public Health, has agreed to serve as chairperson of this committee.

Throughout the term of the project, advisory committee members will be called upon to provide advice on and about activities for which they have particular expertise and experience. In addition to the advisory role, members would have primary responsibility for producing a report that outlines the strengths and weaknesses of existing vital statistics violence data collection reporting and analysis systems.

Violence as a Public Health Problem

Violence and Fatal Injuries

Most age groups in the United States have experienced declines in mortality rates. Adolescents and young adults, however, have sustained appreciable rate increases. Violent deaths account for more than one-third of all deaths in the 15-to-44-years age group. Violent deaths from suicide and homicide have been shown to be important contributors to the overall mortality increase among young adults.[1] For example, between the mid-1950s and 1978, the suicide rate among young people 15-to-24 years of age more than tripled, moving suicide from the fifth leading cause of death in this age group in 1960 to the third leading cause in 1978.[2] White males have the highest suicide rate and have experienced the greatest degree of increase in suicides. Homicide has also contributed to the overall increase in the death rate among young adults. Homicide is the leading cause of death in the U.S. for black males 15-to-24 years of age.[3] The 1978 homicide rate for black males was 25 percent higher than the 1970 rate.[4] During the time period from 1977 to 1979, all states in the Southwestern Region except Oklahoma had a homicide rate higher than the U.S. rate. During the same time period, Arkansas, New Mexico, and Oklahoma had suicide rates higher than the U.S. rate.

The Centers for Disease Control recently released two surveillance reports on homicide[5] and suicide.[6] These reports used vital statistics data to document the magnitude of homicide and suicide in the United States. The homicide report examined national trends for the years 1970 to 1978, and the suicide report examined national trends for the years 1970 to 1980. The proposed project will use the methodology employed in these reports to document trends in homicide and suicide mortality in each of the five states and the region as a whole. However, since states have more timely access to their own vital statistics data, the analyses will cover the years 1977 to 1986.

Violence and Nonfatal Injuries

Nonfatal intentional injuries resulting from assault, child-abuse, spouse abuse, and rape also exact an enormous toll on individuals and society. Each year more than 100,000 cases of child abuse are reported to health and human service agencies in this region. Forcible rape is a violent crime, and offenses known to the police are analyzed by the FBI. Four of the five states in this region consistently have a forcible-rape rate higher than the national rate.

1990 Stress and Violence Health Objectives

One mechanism for increasing the awareness of violence as a societal problem already has been initiated by the U.S. Department of Health and Human Services. In its 1980 document, an outline of national health objectives for 1990 is presented.[7] Three of the fourteen 1990 national stress and violence objectives are directed toward a reduction in death and injury due to violence:

- By 1990, the rate of suicide among people aged 15-to-24 should be below 11 deaths per 100,000 population. (In 1978, the suicide rate for this age group was 12.4 per 100,000).
- By 1990, the death rate from homicide among black males should be reduced to below 60 deaths per 100,000 population. (In 1978, the homicide rate for this group was 72.5 per 100,000).
- By 1990, injuries and deaths inflicted on children by abusing parents should be reduced by 25 percent. (Reliable baseline data are unavailable; estimates vary from 200,000 to a million cases of child abuse occurring each year in this country).

Purpose of Proposed Project

Despite the magnitude of the problem of violence in the United States, there is no uniform state or regional system dedicated to a coordinated system for monitoring and surveillance of intentional injuries. Many state and private agencies collect data related to intentional injuries and deaths. To date, this information has not been systematically examined in a coordinated effort. Clearly, before effective intervention strategies can be developed to reduce the tremendous toll due to violent behavior, more information must be obtained regarding that behavior. Continuous systematic data collection models are essential for the scientific study of injury.[8, 9] The purpose of the proposed project is to establish such a system in the five-state region; a system that will identify and assess data sources, analyze mortality data, and disseminate the results to organizations and agencies that can facilitate prevention initiatives.

Monitoring and surveillance provide information that can be used to estimate the levels of diseases for various populations, study their causes, reveal possible courses of intervention, and estimate apparent effects of intervention.[10] In 1978, a select committee of the World Health Organization (WHO) offered the following definitions of the concept of monitoring and surveillance in public health:

- Monitoring is an integrated system of making observations on health and environmental factors, and of scrutinizing, storing, and retrieving these data for specified purposes of protecting and improving human health.
- Health surveillance is the closely associated system of collating and interpreting data collected from monitoring programs (and from any other relevant sources), with a view to the detection and evaluation of health problems on which remedial action can be based.[11]

Official mortality statistics are unique in their scope. However, the information derived from vital statistics records and hence the validity of intentional injury mortality statistics have been questioned in recent years. These systems need to be examined

carefully for their potential usefulness in conducting epidemiologic studies and their contribution to an understanding of intentional injuries. The proposed project will involve a panel of national and regional scientists in the assessment and evaluation of each state vital statistics system.

The proposed project will provide a model for the monitoring of violence in a region with diverse social, economic and political considerations. It will also demonstrate to other areas of the country the usefulness of a regional monitoring and surveillance system in identifying violent health behavior initiatives. For each state and the region as a whole, the system will be the initial step in the promotion of strategic planning of violence intervention programs. The experience in each state coupled with that of the region will demonstrate the implementation of this model under a variety of circumstances.

Project Methodology

A monitoring and surveillance system that gathers, analyzes and integrates violence-related information will be developed. The system will have two levels of operation. The first level is a regional coordinating center, located within the Texas Department of Health Bureau of Epidemiology. Project personnel will analyze the past ten years of intentional injury mortality data for each state and the region as a whole. At this level, and augmenting the center, will be an external policy advisory committee. The second level of operation will occur within each individual state health department, where an epidemiologist will be located.

Sources of Data

At the regional level, homicide and suicide deaths will be analyzed using death certificate data from each state and Bureau of Census population estimates. The death certificate category homicide includes ICDA codes E960-E978. The death certificate category suicide includes ICDA codes E950-E959. Intentional injury deaths will be characterized by:

- age, sex, and ethnicity
- geographic distribution, i.e., state, county, and/or city of occurrence
- time of day, week, month, and year
- circumstances of death, i.e., weapon used

For their own purposes, social service agencies and public safety agencies collect data on fatal and nonfatal intentional injuries. These data are potential sources of information for state health departments. Little research has been done on the advantages and limitations of these data sets, and an assessment of their value for intentional injury surveillance and monitoring has not been completed. These "other" data sources will provide the basis for most of the state-level activities.

Objectives

Objectives on a regional level of operation are 1) to use vital statistics data and determine with respect to selected demographic characteristics the incidence and ten-year trends of fatal intentional injuries within a five-state area; 2) to assess the quality and usefulness of fatal intentional injury data in the existing vital statistics reporting systems; and 3) to

summarize and disseminate mortality data as they pertain to the 1990 Health Objectives for homicide and suicide.

Objectives on a state level of operation are 1) to develop a state-specific comprehensive inventory of data sources available for the monitoring and surveillance of intentional injuries; 2) to determine potential opportunities for collaborative effort in intentional injury prevention; and 3) to demonstrate the usefulness of "other data sources" in describing the incidence of one specific intentional injury problem; and 4) to disseminate the information to the public and policymakers in each state.

Tasks, Responsibilities, and Time Framework

On a regional level of operation, the first two tasks will occur sequentially. The third task will be ongoing throughout the project.

1. Use appropriate statistical procedures to characterize and describe for the ten-year period of 1976 through 1985 the state-level and regional-level vital statistics data. *Responsibility*: regional project staff in coordination with regional project director and CDC consultants. *Time:* 8 months.
2. Prepare a report of the state-specific and regional findings of the mortality analysis. *Responsibility*: regional project staff and regional project director in coordination with advisory panel. *Time:* 4 months.
3. By interviews, discussion, and review of reports determine the strengths and limitations of the current vital statistics reporting systems for each state and the region as a whole. Determine and prepare state and regional recommendations for improvement. Prepare a report summarizing the findings and recommendations. *Responsibility*: regional project director in coordination with project advisory committee, and CDC consultants. *Time:* ongoing.

On a state level of operation, the first six tasks will occur sequentially. The seventh task will be ongoing throughout the project.

1. Each state will submit a data tape with the specified information to the regional center. *Responsibility:* state project staff. *Time*: 1 month.
2. Identify persons, agencies, and organizations that are involved in the surveillance, monitoring, and prevention of intentional injuries. *Responsibility*: state project staff. *Time*: 1 month.
3. During task #2, potential intentional injury data bases will be identified. For each of these and in coordination with the regional center a data/text file will be prepared with the following information: source of data, storage form, specific data sets, accuracy, data strengths and weaknesses, documentation, coverage, availability. *Responsibility*: state project staff in coordination with regional center. *Time:* 2 months.
4. Determine by interviews, discussions, and review of reports the appropriateness of using these data to report intentional injuries and deaths on an on-line basis. Determine the feasibility of a state-level and regional-level active reporting system. *Responsibility*: project staff in coordination with regional center. *Time*: 3 months.

5. Using one "other" data source, prepare a report that describes the incidence of one intentional injury problem. *Responsibility*: project staff in coordination with regional center. *Time*: 3 months.
6. For suicide, homicide, and child abuse, prepare a set of one-page graphic fact sheets to illustrate the personal and human tragedy associated with violence. *Responsibility*: state project staff in consultation with regional center. *Time*: 2 months.
7. Working with public information offices of the state health departments, regularly disseminate results of the regional and state-level analyses. *Responsibility*: state project staff. *Time*: ongoing.

Project Evaluation

It is intended that evaluation of this project be a continuous process and that appropriate mid-course corrections be applied. The following milestones will be accomplished during the one-year grant period and will serve as measurable indicators of progress at the regional level.

1. Determination of variables to be examined
2. Number of states sending data tapes
3. Completion of mortality analyses of homicide and suicide trends
4. Number of state mortality reports completed
5. Regional comparison report completed
6. Determination of criteria for assessment of current vital statistics systems
7. Number of state vital statistics system assessments completed
8. Completion of state and regional system reports

The following milestones will be accomplished during the one-year grant period and will serve as measurable indicators of progress for each state.

1. Number of information sources surveyed
2. Completion of report summarizing assessment results
3. Number of fact sheets prepared and disseminated
4. Number of press releases disseminated

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11. Lwanga, S. 1978. "Statistical Principles of Monitoring and Surveillance in Public Health." *Bulletin of the World Health Organization*, vol. 56, no. 5, pp. 713-22.

Appendix D

Biographies of Participants

Faye G. Abdellah, R.N., Ed.D., LL.B., is the Deputy Surgeon General of the United States Public Health Service, Department of Health and Human Services. She serves as the focal point for nursing and chief advisor on long-term care policy within the Office of the Surgeon General. She has been the recipient of 40 academic awards and professional honors, including the unique honor of being elected as a charter fellow of the American Academy of Nursing. She is the author or coauthor of more that 120 publications. Some of her books have been published in numerous languages. She served as staff director of the secretary of Health, Education and Welfare's Committee to Study Extended Roles for Nurses whose efforts resulted in the milestone publication, *Extending the Scope of Nursing Practice*. She serves or has served on many state and district nursing association work groups and committees developing standards of nursing practice, establishing credential standards and providing workshops in nursing research. She holds the rank of Rear Admiral in the Public Health Service. She is now serving as a principal in the revitalization of the V.S.P.H.S. commissioned corps.

Roy B. Allen, Ph.D., is a Criminology Research Analyst at the Southwest Center for the Study of Hospital and Health Care Systems in Houston, Texas. He received his doctorate in criminology in 1986 from Florida State University. He has published articles on criminology research in the *Journal of Criminal Justice*, *Criminal Justice Review*, and *Journal of Quantitative Criminology*. He is a member of the Community Advisory Council Standing Committee on Interpersonal Violence at the University of Texas Health Science Center at Houston.

Kenneth Z. Altshuler, M.D., is a Professor and Chairman of the Department of Psychiatry, Southwestern Medical School, in Dallas, Texas. He received his medical degree from the University of Buffalo. He has written over 100 papers and books and researched extensively in the fields of genetics, geriatrics, early total deafness, psychoanalysis, and sleep and dreams as they relate to psychiatry. He received the Thornton Wilson Award in Genetics and Preventive Psychiatry, the Merit Award of the Association for Psychoanalytic Medicine, an Honorary Doctorate of Science from Gallaudet College in Washington, D.C., and the Certificate of Significant Achievement from the American Psychiatric Association. He was one of the founders and Vice-President of the Association of Directors of Medical Student Education in Psychiatry, which made him an honorary life member. He is a founding member and first President of the Dallas Psychoanalytic Study Society and a training analyst and moving force in the recently established New Orleans Psychoanalytic Institute at Dallas. In 1983 he was installed as the first holder of the Stanton Sharp Chair in Psychiatry.

Ron J. Anderson, M.D., is President and Chief Executive Officer, Parkland Memorial Hospital in Dallas, Texas. He is also Associate Professor of Internal Medicine at Southwestern Medical School. He received his medical degree from the University of Oklahoma Health Science Center School of Medicine. He was awarded the Anderson Award in Law and Medicine from Baylor University Law School, the Commendation for Meritorious Service on the Indigent Care Task Force from the State of Texas and has been cited in *Who's Who in America* and *Who's Who in the South and Southwest*, and has published extensively. He is Diplomate of the American Board of Internal Medicine and American Board of Medical Examiners.

Paul H. Blackman, Ph.D., is Research Coordinator and Deputy Director, Information and Members Services, Institute for Legislative Action and National Rifle Association. He received his doctorate from the University of Virginia in 1970. He has done extensive research in the fields of gun control, criminology, and political analysis. He has written many articles and papers on presidential politics for the Heritage Foundation and Congress, and more recently on the criminal justice system and firearms.

Lee P. Brown, Ph.D., is Police Chief of Houston, Texas. He established the Criminal Justice Program at Portland State University, was Associate Director of the Institute for Urban Affairs and Research, and Professor of Public Administration and Director of the Criminal Justice Program at Howard University in Washington, D.C. He served as Sheriff and Director of Public Safety for Multnomah County in Oregon and was Director of the Department of Justice Services, a department comprising all the county's criminal justice agencies. He was Public Safety Commissioner in Atlanta, Georgia, for four years. He received his doctorate in criminology from the University of California at Berkeley. He has authored many articles and papers on police management, community relations, crime, and the criminal justice system. He is coauthor of a book, *The Police and Society: An Environment for Collaboration and Confrontation.*

Michael E. Cavender, B.A., M.Ed., is President of Dallas Challenge, Inc., a nonprofit agency serving chemically dependent adolescents through prevention, intervention, treatment, and aftercare. He was Director of Student Personnel Services for Plano Independent School District and Principal for the Richardson Independent School District. He received his master's degree in education from North Texas State University and attended the Johnson Institute for Chemical Dependency Training. He serves on the board of Dallas CAN and the board of Chemical People Task Force.

Richard H. Collins, B.S., is President of Associated Texans Against Crime and President and Founder of the Texas Foundation for Conservative Studies. He is active in many businesses and is Chairman of the Board of The First Jefferson Company and Intercapco, Inc. He is a graduate of Southern Methodist University.

Ronald E. Cowart, M.A., is an Officer in the Dallas Police Department currently assigned to the East Dallas Police Storefront, which he helped create. The storefront serves as a cultural liaison between the city and recent immigrants from Cambodia, Cuba, Laos, Vietnam, Mexico, and Thailand. He is Chairman of the Dallas Refugee Council and serves on the boards of directors of the Asian-American Advisory Committee for Dallas Independent School District, the Dallas-Fort Worth Refugee Interagency, and the East Dallas Health Coalition. He is on the boards of advisors for the Dallas Alliance of Southeast Asian Americans, the Association of Cambodian Refugees, and the East Dallas Cooperative Parish. He also serves as a committee member of the Texas Mental Health/Mental Retardation agency and the North Texas Illiteracy Task Force. He is a Vietnam veteran and is active in attempting to reduce crime in the Southeast-Asian community of Dallas.

Suzanne Danilson, M.S.W., is Administrator, Maternal and Child Health, Louisiana Office of Preventative and Public Health Services. She was formerly Administrator of Louisiana State Central Registry and Child Abuse Hotline and has served as a consultant to various groups on family crises, sexual assault, and child protective services. She received her master's degree in social work from Tulane University in New Orleans. She is President of the Council on Abused and Battered Children and a member of the National Committee for the Prevention of Child Abuse, Juvenile Justice Taskforce, Louisiana Public Health Association and the Association of Maternal and Child Health and Crippled Children's Directors. She has written many papers and articles on child abuse and other public health issues.

Jeffrey M. Davis, M.D., M.P.H., is Chief, Maternal and Child Health Bureau, New Mexico Department of Health and Environment, and Assistant Professor of Pediatrics, the University of New Mexico School of Medicine. He received his medical degree from Columbia College of Physicians and Surgeons and his master of public health degree from the University of California at Berkeley. He was awarded the Columbia Physicians and Surgeons Student Research Fellowship, the National Endowment for the Humanities Fellowship and is board-certified in pediatrics and medical genetics. He serves as investigator for four maternal and child health special projects of regional and national significance grants, including the Native American Adolescent Injury Prevention Project.

Louis A. DeNino, Ph.D., is Assistant Professor of Economics in Human Ecology and Community Health Practice at the University of Texas Health Science Center at Houston, School of Public Health. He is currently researching the marginal cost of hospital care for the indigent, the tax dollar cost of teenage fertility, and cost-effectiveness of a teen prenatal clinic at Hermann hospital. He has written many articles and papers on medical economics. He serves as a consultant for the Southwest Center for the Study of Hospital and Health Care Systems; the President's Council on Aging; and the Hastings Center Institute for Society, Ethics, and the Life Sciences. He is a member of the American Economic

Association, the Western Economics Association, the Population Association of America, and the American Public Health Associations.

Ruth E. Dennis, Ph.D., is Professor of Sociology at Austin Peay State University and Director of Research at Meharry State College. She received her doctorate from Michigan State University. She was awarded the Lane College Outstanding Educator's Award and Outstanding Citizen's Award from the state of Tennessee. She is past President of the Association of Social and Behavioral Scientists and the National Hook-up of Black Women. She is also active in professional and civic organizations including the American Public Health Association, the American Association of Suicidology, the Association of Behavioral Sciences and Medical Education, and the NAACP. She is the author of many articles and papers including, "Homicide: Social Cost to Families and Communities" and "Social Stress and Mortality Among Young Black Males."

Sara Reed DePersio, M.D., M.P.H., is Chief of Maternal and Child Health Medical Services and Director of Maternity and Family Planning Division of Oklahoma State Health Department. She is a Clinical Professor of Obstetrics and Gynecology at the University of Oklahoma College of Medicine, and Associate Member, Graduate Faculty, College of Public Health. She has received one of the "Ten Outstanding Young Women in America" awards. Her professional organization participation includes President, National Association of Maternal and Child Health and Crippled Children's Services; Director and active membership in the American Medical Association, American Public Health Association, and the Oklahoma State Medical Association. She is the author or coauthor of several articles and papers on public-health issues.

Jeanne P. Deschner, Ph.D., is Assistant Professor of Social Work, Graduate School of Social Work, the University of Texas at Arlington. She is a member of the Council for Social Work Education, the American Psychological Association, and the Association for the Advancement of Behavior Therapy. She is a former President of the Houston Behavior Therapy Association and founder and former President of the Houston Achievement Place. She has written extensively on social work issues and on her specialty, the battering couple. She is the author of *The Hitting Habit: Anger Control for Battering Couples*.

John M. Dyer, M.D., M.P.H., is an Assistant Surgeon General, United States Public Health Service, and Regional Health Administrator, region VI. He received his medical degree from the University of Tennessee and his masters degree in public health from the University of California at Berkeley. He is a fellow of the American Academy of Pediatrics (community health and military pediatrics sections) and a member of the Ambulatory Pediatric Society. He has been awarded the PHS Meritorious Service Medal and Commendation Medal and the U.S. Coast Guard Unit Commendation Award.

desAnges C. Eckert, M.P.A., is Central Region Program Manager, Oklahoma Department of Mental Health. She is former Director of Planning and Program

Development for the Arkansas Division of Mental Health. Her professional memberships have included the Association of Mental Health Administrators, the American Society of Public Administration, the American Red Cross, the NIMH Staff College Curriculum Development Committee, and the Arkansas Department of Human Services Task Force. She is also active in several civic and community organizations. She has written several articles and papers on mental-health issues.

Clairece Feagin, Ed.M., teaches American and Texas government through the Independent Learning Division of the University of Texas and is the author of a variety of curriculum materials in both government and sociology. She is coauthor of *Discrimination American Style*. She researched elder abuse in Texas for the Texas Senate Interim Subcommittee on Elder Abuse and wrote a report on elder abuse for the 70th Legislature. She is currently Program Director for Guardians of Travis County, a volunteer guardianship program serving abused, neglected, and exploited elders.

Jerry P. Flanzer, D.S.W., is Professor of Social Work at the University of Arkansas at Little Rock. He was awarded the HIAS Foundation Fellowship, NIMH Fellowship, and Donaghey Foundation Teaching Fellowship and is cited in *Who's Who in Southwest* and *Personalities in the South*. He has been Director of the Graduate School of Social Work Family Center, the Arkansas Alcohol/Child Abuse Demonstration Project, and the Mid-America Institute on Violence in Families at the University of Arkansas. He has authored many articles on family violence including "Parental Drinking and Adolescent Abuse" (Proceedings of the second annual Congress on Alcoholism, Tel Aviv, 1983), "The Vicious Circle of Alcoholism and Family Violence" (*Alcoholism Magazine*, 1981) and contributed two chapters to *The Many Faces of Family Violence*.

Ralph F. Frankowski, Ph.D., is Professor of Biometry, School of Public Health, the University of Texas at Austin and Adjunct Professor of Mathematical Sciences, Rice University. He received his doctorate in biostatistics and his master of public health degree from the University of Michigan. He serves on the advisory board of Texas Head Injury Foundation and the National Institute of Rehabilitation, Research, and Training Center Advisory Council. He has authored or coauthored many articles, including "Trauma in Texas" (*Texas Medicine*, 1983), "Injury Surveillance Systems--Strengths and Weaknesses and Issues Workshop" (*Public Health Reports*, 1985), and "The Demography of Head Injury in the U.S." (*Neurotrauma: Treatment Rehabilitation and Related Issues*, 1986).

Shervert H. Frazier, M.D., was Director of the National Institute of Mental Health. He was formerly Professor of Psychiatry at Harvard Medical School. He has received the Mayo Foundation Distinguished Alumnus Award and the American College of Psychiatrists' Bowis Award. He is a former President of the American College of Psychiatrists and the Association for Research in Nervous and Mental Diseases as well as the American Board of Psychiatric Association and the American Psychiatric Press. He has appeared on national network programs and has authored or coauthored nearly 100

chapters, articles, and papers on general medical and psychiatric issues, including "Mental Health" in the *Americana Annual of 1986*. He is now in Boston, Massachusetts at McLean Hospital.

Arthur S. Funke, Ph.D., is Chief Psychologist for the Division of Maternal and Child Health, Bureau of Community Health Delivery Assistance, United States Public Health Service. He is Chairman of Healthy Mothers' Healthy Babies Coalition and a member of the Interagency Panel of Research and Development in Hospice International. He received his doctorate in psychology from Pennsylvania State University and has received the Award for Outstanding Contributions in Mental Health from the Association for Mental Health and a Certificate of Appreciation from the Task Force on the President's Commission on Mental Health. He has written many articles and papers on mental health and psychology including, "New Federal Initiative for Psychologists as Individual and Population Problem Solvers," presented to the American Psychological Association.

Catalina Esperanza Garcia, M.D., is an Anesthesiologist in private practice in Dallas. She is the first female Hispanic graduate of Southwestern Medical School. Her professional membership includes the American Medical Association, the Texas Medical Association, Mexican-American Physicians, and the American Society of Anesthesia. She is actively involved in many civic and community organizations including the Dallas Area Rapid Transit Board, Dallas Alliance, the Family Place, and the Board of the Center for Housing Resources. She is a founding member of Mexican-American Business and Professional Women of Dallas and Membership Chair of the Hispanic Issues Forum.

Robert A. Geffner, Ph.D., is Associate Professor of Psychology at the University of Texas at Tyler and holds the J.S. Hudnall Endowment Professorship of American Affairs. He is also Director of the Family Violence Research Program, a national clearinghouse for spouse abuse research, and is a member of the editorial board of the *Journal of Family Violence*. He is past President of the East Texas Psychological Association and member of the Texas State Ethics Committee for Psychologists. He has authored many articles and chapters in various publications, including "Research Concerning Family Violence" (*Handbook of Family Violence*, in press) and "A New Program for Reducing Marital Violence," (*Bulletin of the Texas Council on Family Violence*, 1984).

Fernando Guerra, M.D., M.P.H., is a Pediatrician in private practice in San Antonio. He is a consultant to the Santa Rosa Medical Center, Bexar County Child Welfare, and a member of the National Advisory Council on Migrant Health and the Physicians Task Force: Hunger in American. He serves on the Board of Directors of the National Committee for Prevention of Child Abuse and Neglect. He is a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. He is a former Kellog Fellow at the Harvard School of Public Health. He is active in several civic and community organizations including the Bexar County Mental Health/Mental Retardation Professional Advisory Committee and the U.S./Mexico Border Health Association. He has

written numerous articles and papers on child and adolescent health care as well as hispanic health issues.

Keith O. Harries, Ph.D., is Professor and Chairman of Geography at the University of Maryland, Baltimore County. He was Interim Director of the Center for Criminal Justice at Oklahoma State University and received his doctorate from the University of California at Los Angeles. He has written many articles and chapters on public health issues and is the author of *The Geography of Crime and Justice, Crime and the Environment, Human Geography: Culture, Interaction and Economy,* and *The Criminal Justice System and Blacks.*

Larry J. Hebert, M.D., is Professor of Pediatrics, Louisiana State University Medical College; Chief of Pediatrics at Earl K. Long Memorial Hospital; and Medical Director, Child Protection Programs, Louisiana Department of Health and Human Resources. He is also Chairman of Louisiana Children's Trust Fund, serves on the Board of Directors of Baton Rouge Chamber of Commerce and the Baton Rouge Council for Child Protection, and is a member of the Louisiana Commission on Children and Youth. He hosts "House Calls," a medical information program in Baton Rouge. He is a Diplomate of the American Board of Pediatrics. He was awarded the Outstanding American in the South Award, the Aesculapean Honor Society Outstanding Professor Recognition Award, and the 1985 Excellence in Medical Journalism Award by the Louisiana State Medical Society. He has authored many articles and chapters on child abuse.

Anne S. Helton, R.N., M.S., is a Clinical Associate, College of Nursing, Texas Woman's University. She is a specialist in prevention of battering during pregnancy. She received her M.S. in clinical health nursing from Texas Woman's University. She has authored several articles on spouse abuse and domestic family violence.

Lois Haight Herrington, LL.B., J.D., is former Assistant Attorney General of the United States. She headed the Office of Justice Programs (OJP) in the Department of Justice. She also serves as a National Correspondent to the United Nations Congress on the Prevention of Crime and the Treatment of Offenders. She previously served as Chairman of the President's Task Force on Victims of Crime.

She is currently Chairman of the National Crime Prevention Coalition and a member of the advisory board of Crime Stoppers International, the Federal Council on Juvenile Justice and Delinquency Prevention, the Advisory Board of the National Institute of Corrections, as well as the National Sheriff's Association's Standards, Ethics, Education, and Training Committee. She is also a member of the Advisory Committee on Rape Prevention and Control and the National Advisory Board on Child Abuse and Neglect, both of the Department of Health and Human Services. She served as a member of the United States Delegation to the United Nations Decade for Women in Nairobi, Kenya, and was a member of the United States Delegation to the Seventh United Nations Congress on the Prevention of Crime and Treatment of Offenders in Milan, Italy.

She has been a member of the Alameda County Women's Coalition on Domestic Violence, the California Sexual Assault Investigators, and the Contra Costa County Child Development Council. She was a Coordinator for the Probation and Courts of Domestic Violence's diversion programs and the Drug Diversion and Education Program in Contra Costa County. She was also a participant in the National Conference of Juvenile Justice and Judges Seminars. She has written numerous articles and papers on crime and violence.

Gregory R. Istre, M.D., is State Epidemiologist and Medical Chief of Epidemiology Service, Oklahoma State Department of Health. He has received the University of Oklahoma Pediatrics Resident Teaching Award. He is Diplomate of the National Board of Medical Examiners and the American Board of Pediatrics. His professional memberships include the American College of Preventative Medicine, American College of Epidemiology, American Public Health Association, Oklahoma Public Health Association, and Oklahoma State Medical Association. He has written extensively on epidemiology issues, including "Management of Possible Rabies Exposure," a chapter in *Critical Decisions in Trauma.*

Sue Kelly James, M.S., C.R.C., is Senior Staff Coordinator and Counselor at the Dallas County Rape Crisis Center, Southwest Regional Coordinator for Forensic Mental Health, and Codirector of Southwest Associates Against Sexual Assault. She was First Vice-President, Board of Directors of the Texas Crime Prevention Association, and was chosen one of the top 25 experts in the U.S. by the National Institute of Mental Health. She serves as a consultant in sexual assault training for many police departments, hospitals, schools, and agencies. She is the author of *Rape Attack: Submission or Resistance, Utilizing the Media for Rape Prevention, and Rape Defense: A Complex Issue.*

Eddie Bernice Johnson, LL.B., was Vice-President, Governmental and Community Affairs of the Visiting Nurses Association of Texas. She was Director of HEW, region VI and served three terms as a State Representative in the Texas House of Representatives. She serves on the boards of many organizations including the Economic Development Advisory Board, Goals for Dallas, Dallas Chapter of the NAACP, Planned Parenthood of Greater Dallas, Inc., and Regional Health Planning Committee (NCTCOG). She is a life member of the NAACP and the YWCA and past President of the National Council of Negro Women. She was awarded the Outstanding Black Achievement Award, Phi Delta Kappa, and the Outstanding Contributions to Humanity Award by the National Optometric Association. She was the first black woman elected to the Texas House of Representatives from Dallas County and the first woman from Dallas County since 1935. She was elected to the Texas State Senate, November 1986.

Blair Justice, Ph.D., is Professor of Psychology, the University of Texas Health Science Center at Houston, School of Public Health; Chairman, Standing Committee on Interpersonal Violence; and Faculty Associate, Center for Health Promotion, Research, and Development. He is former Science Editor, Houston Post and former Project Director of

"Project for Early Prevention of Individual Violence." He has been listed in *Who's Who in America*, *Who's Who in the World*, and *International Who's Who in Medicine*. He has won 26 awards for news, science, and medical writing for the public, including four national awards and a Texas Writer's Roundup award. He is former Chairman of the American Public Health Association and a Fellow, American College of Psychologists. He has written over 200 articles, papers, and chapters in various publications. He is the author of *Who Gets Sick: Thinking and Health* (in press).

Judge Edward Kinkeade is a Texas State District Court (64th) Judge in Dallas.

Thomas L. Lalley, Ph.D., is Deputy Chief, Antisocial and Violent Behavior Branch, National Institute of Mental Health. He was awarded the Fulbright Scholarship, the Public Health Service Superior Service Award and Administrator's Award, Alcohol, Drug Abuse, and Mental Health Administration. He has authored several articles and chapters on antisocial and violent behavior in various publications including *Issues in Law Enforcement: Essay and Case Studies*.

Joseph Little, LL.B., is the Branch Chief for Judicial Services, Bureau of Indian Affairs, which provides support service to the Courts of Federal Offenses and tribal court systems throughout the country. He was the Executive Director of the New Mexico Office of Indian Affairs and has served as General Counsel to the All Indian Pueblo Council and other Pueblo governments. He received his law degree from the University of New Mexico School of Law. He is an enrolled member of the Mescalero Apache Tribe.

Linda E. Lloyd, M.S., M.B.A., is acting Division Director, Environmental Epidemiology, Texas Department of Health, and Adjunct Professor, Southwest Texas State University. She has written many papers and articles on public-health issues, including "Statistical Problems Associated with Self-Reported Health Behavior," Texas Public Health Association, 1986; and, "Trauma Registries: Strengths and Weaknesses," Texas Rural Health Association, 1986.

Ann C. Maney, Ph.D., is Branch Chief, Mental Health Resource Policy Branch, National Institute of Mental Health in Rockville, Maryland. She was Head, National Center for the Prevention and Control of Rape, and Project Director of Mental Health Study Center. She has been a NIMH Postdoctoral Fellow, Weil Scholar, Carnegie Scholar, and received the Shepp Foundation Award and Freedom Foundation Award. She is active in several professional organizations including, the American Public Health Association, the American Association for Advancement of Science and the American Sociological Association.

Michael R. Mantell, Ph.D., is Chief Psychologist, San Diego Police Department, and Assistant Clinical Professor of Psychiatry, University of California, San Diego Medical School, and teaches in the Delinquency Control Institute at the University of Southern

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Appendix E

Convention-Planning Pointers

During the production of the 1986 conference, several issues developed that required resolution, and the following information may assist future conference planners in avoiding problems:

1. Contact selected conference presenters frequently during the two months preceding the conference.
2. Have a list of substitutes available.
3. Audiovisual equipment may fail despite all precautions. Have an audiovisual repair man on standby at the conference. It is a good investment.
4. Good parking arrangements are critical. Coffee service on time is critical. A monitored message board is critical. These are necessities.
5. Appoint a business coordinator to handle financial payments that must be made during the conference.
6. Try to avoid copying of presenters' papers during the conference. It can become expensive and time consuming.
7. Use volunteers. Appoint a volunteer captain to coordinate them.
8. For maximum conference facilitation, assume all guests attending the conference will arrive without paper and pencil, will need a telephone, and will not be exactly on time.
9. Keep smiling when disaster strikes. It will pass. The results are worth all the effort.